TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 120
MEDICAL ASSISTANCE PROGRAMS

SUBPART A: GENERAL PROVISIONS

Section

SUBPART B: ASSISTANCE STANDARDS

Section

SUBPART C: FINANCIAL ELIGIBILITY DETERMINATION

Section

SUBPART D: MEDICARE PREMIUMS

Section

SUBPART E: RECIPIENT RESTRICTION PROGRAM

Section
120.80 Recipient Restriction Program

SUBPART F: MIGRANT MEDICAL PROGRAM

Section
120.90 Migrant Medical Program (Repealed)
120.91 Income Standards (Repealed)

SUBPART G: AID TO THE MEDICALLY INDIGENT

Section
120.200 Elimination Of Aid To The Medically Indigent
120.208 Client Cooperation (Repealed)
120.210 Citizenship (Repealed)
120.211 Residence (Repealed)
120.212 Age (Repealed)
120.215 Relationship (Repealed)
120.216 Living Arrangement (Repealed)
120.217 Supplemental Payments (Repealed)
120.218 Institutional Status (Repealed)
120.224 Foster Care Program (Repealed)
120.225 Social Security Numbers (Repealed)
120.230 Unearned Income (Repealed)
120.235 Exempt Unearned Income (Repealed)
120.236 Education Benefits (Repealed)
120.240 Unearned Income In-Kind (Repealed)
120.245 Earmarked Income (Repealed)
120.250 Lump Sum Payments and Income Tax Refunds (Repealed)
120.255 Protected Income (Repealed)
120.260 Earned Income (Repealed)
120.261 Budgeting Earned Income (Repealed)
120.262 Exempt Earned Income (Repealed)
120.270 Recognized Employment Expenses (Repealed)
120.271 Income From Work/Study/Training Program (Repealed)
120.272 Earned Income From Self-Employment (Repealed)
120.273 Earned Income From Roomer and Boarder (Repealed)
120.275 Earned Income In-Kind (Repealed)
120.276 Payments from the Illinois Department of Children and Family Services (Repealed)
120.280 Assets (Repealed)
120.281 Exempt Assets (Repealed)
120.282 Asset Disregards (Repealed)
120.283 Deferral of Consideration of Assets (Repealed)
120.284 Spend-down of Assets (AMI) (Repealed)
120.285 Property Transfers (Repealed)
120.290 Persons Who May Be Included in the Assistance Unit (Repealed)
120.295 Payment Levels for AMI (Repealed)

SUBPART H: MEDICAL ASSISTANCE – NO GRANT (MANG) ELIGIBILITY FACTORS

Section

SUBPART I: SPECIAL PROGRAMS

AUTHORITY: Implementing Articles III, IV, V and VI and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and 12-13] and implementing the federal Deficit Reduction Act of 2005.

SOURCE: Filed effective December 30, 1977; peremptory amendment at 2 Ill. Reg. 17, p. 117, effective February 1, 1978; amended at 2 Ill. Reg. 31, p. 134, effective August 5, 1978; emergency amendment at 2 Ill. Reg. 37, p. 4, effective August 30, 1978, for a maximum of 150 days; peremptory amendment at 2 Ill. Reg. 46, p. 44, effective November 1, 1978; peremptory amendment at 2 Ill. Reg. 46, p. 56, effective November 1, 1978; emergency amendment at 3 Ill. Reg. 16, p. 41, effective April 9, 1979, for a maximum of 150 days; emergency amendment at 3 Ill. Reg. 28, p. 182, effective July 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 33, p. 415, effective August 18, 1979; amended at 3 Ill. Reg. 38, p. 243, effective September 21, 1979; peremptory amendment at 3 Ill. Reg. 38, p. 321, effective September 7, 1979; amended at 3 Ill. Reg. 40, p. 140, effective October 6, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 22, 1980; amended at 4 Ill. Reg. 10, p. 258, effective February 25, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; amended at 4 Ill. Reg. 27, p. 387, effective June 24, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 37, p. 800,

effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 27, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1134, effective January 26, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; amended at 5 Ill. Reg. 7104, effective June 23, 1981; amended at 5 Ill. Reg. 8041, effective July 27, 1981; amended at 5 Ill. Reg. 8052, effective July 24, 1981; peremptory amendment at 5 Ill. Reg. 8106, effective August 1, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10079, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10095, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10113, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10124, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10131, effective October 1, 1981; amended at 5 Ill. Reg. 10730, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 10760, effective October 1, 1981; amended at 5 Ill. Reg. 10767, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 11647, effective October 16, 1981; peremptory amendment at 6 Ill. Reg. 611, effective January 1, 1982; amended at 6 Ill. Reg. 1216, effective January 14, 1982; emergency amendment at 6 Ill. Reg. 2447, effective March 1, 1982, for a maximum of 150 days; peremptory amendment at 6 Ill. Reg. 2452, effective February 11, 1982; peremptory amendment at 6 Ill. Reg. 6475, effective May 18, 1982; peremptory amendment at 6 Ill. Reg. 6912, effective May 20, 1982; emergency amendment at 6 Ill. Reg. 7299, effective June 2, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 8115, effective July 1, 1982; amended at 6 Ill. Reg. 8142, effective July 1, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10970, effective August 26, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12293, effective October 1, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 394, effective January 1, 1983; codified at 7 Ill. Reg. 6082; amended at 7 Ill. Reg. 8256, effective July 1, l983; amended at 7 Ill. Reg. 8264, effective July 5, l983; amended (by adding Section being codified with no substantive change) at 7 Ill. Reg. 14747; amended (by adding Sections being codified with no substantive change) at 7 Ill. Reg. 16108; amended at 8 Ill. Reg. 5253, effective April 9, 1984; amended at 8 Ill. Reg. 6770, effective April 27, 1984; amended at 8 Ill. Reg. 13328, effective July 16, 1984; amended (by adding Sections being codified with no substantive change) at 8 Ill. Reg. 17897; amended at 8 Ill. Reg. 18903, effective September 26, 1984; peremptory amendment at 8 Ill. Reg. 20706, effective October 3, 1984; amended at 8 Ill. Reg. 25053, effective December 12, 1984; emergency amendment at 9 Ill. Reg. 830, effective January 3, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 4515, effective March 25, 1985; amended at 9 Ill. Reg. 5346, effective April 11, 1985; amended at 9 Ill. Reg. 7153, effective May 6, 1985; amended at 9 Ill. Reg. 11346, effective July 8, 1985; amended at 9 Ill. Reg. 12298, effective July 25, 1985; amended at 9 Ill. Reg. 12823, effective August 9, 1985; amended at 9 Ill. Reg. 15903, effective October 4, 1985; amended at 9 Ill. Reg. 16300, effective October 10, 1985; amended at 9 Ill. Reg. 16906, effective October 18, 1985; amended at 10 Ill. Reg. 1192, effective January 10, 1986; amended at 10 Ill. Reg. 3033, effective January 23, 1986; amended at 10 Ill. Reg. 4907, effective March 7, 1986; amended at 10 Ill. Reg. 6966, effective April 16, 1986; amended at 10 Ill. Reg. 10688, effective June 3, 1986; amended at 10 Ill. Reg. 12672, effective July 14, 1986; amended at 10 Ill. Reg. 15649, effective September 19, 1986; amended at 11 Ill. Reg. 3992, effective February 23, 1987; amended at 11 Ill. Reg. 7652,

effective April 15, 1987; amended at 11 Ill. Reg. 8735, effective April 20, 1987; emergency amendment at 11 Ill. Reg. 12458, effective July 10, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 14034, effective August 14, 1987; amended at 11 Ill. Reg. 14763, effective August 26, 1987; amended at 11 Ill. Reg. 20142, effective January 1, 1988; amended at 11 Ill. Reg. 20898, effective December 14, 1987; amended at 12 Ill. Reg. 904, effective January 1, 1988; amended at 12 Ill. Reg. 3516, effective January 22, 1988; amended at 12 Ill. Reg. 6234, effective March 22, 1988; amended at 12 Ill. Reg. 8672, effective May 13, 1988; amended at 12 Ill. Reg. 9132, effective May 20, 1988; amended at 12 Ill. Reg. 11483, effective June 30, 1988; emergency amendment at 12 Ill. Reg. 11632, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 11839, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12835, effective July 22, 1988; emergency amendment at 12 Ill. Reg. 13243, effective July 29, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 17867, effective October 30, 1988; amended at 12 Ill. Reg. 19704, effective November 15, 1988; amended at 12 Ill. Reg. 20188, effective November 23, 1988; amended at 13 Ill. Reg. 116, effective January 1, 1989; amended at 13 Ill. Reg. 2081, effective February 3, 1989; amended at 13 Ill. Reg. 3908, effective March 10, 1989; emergency amendment at 13 Ill. Reg. 11929, effective June 27, 1989, for a maximum of 150 days; emergency expired November 25, 1989; emergency amendment at 13 Ill. Reg. 12137, effective July 1, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 15404, effective October 6, 1989; emergency amendment at 13 Ill. Reg. 16586, effective October 2, 1989, for a maximum of 150 days; emergency expired March 1, 1990; amended at 13 Ill. Reg. 17483, effective October 31, 1989; amended at 13 Ill. Reg. 17838, effective November 8, 1989; amended at 13 Ill. Reg. 18872, effective November 17, 1989; amended at 14 Ill. Reg. 760, effective January 1, 1990; emergency amendment at 14 Ill. Reg. 1494, effective January 2, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 4233, effective March 5, 1990; emergency amendment at 14 Ill. Reg. 5839, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 6372, effective April 16, 1990; amended at 14 Ill. Reg. 7637, effective May 10, 1990; amended at 14 Ill. Reg. 10396, effective June 20, 1990; amended at 14 Ill. Reg. 13227, effective August 6, 1990; amended at 14 Ill. Reg. 14814, effective September 3, 1990; amended at 14 Ill. Reg. 17004, effective September 30, 1990; emergency amendment at 15 Ill. Reg. 348, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 5302, effective April 1, 1991; amended at 15 Ill. Reg. 10101, effective June 24, 1991; amended at 15 Ill. Reg. 11973, effective August 12, 1991; amended at 15 Ill. Reg. 12747, effective August 16, 1991; amended at 15 Ill. Reg. 14105, effective September 11, 1991; amended at 15 Ill. Reg. 14240, effective September 23, 1991; amended at 16 Ill. Reg. 139, effective December 24, 1991; amended at 16 Ill. Reg. 1862, effective January 20, 1992; amended at 16 Ill. Reg. 10034, effective June 15, 1992; amended at 16 Ill. Reg. 11582, effective July 15, 1992; amended at 16 Ill. Reg. 17290, effective November 3, 1992; amended at 17 Ill. Reg. 1102, effective January 15, 1993; amended at 17 Ill. Reg. 6827, effective April 21, 1993; amended at 17 Ill. Reg. 10402, effective June 28, 1993; amended at 18 Ill. Reg. 2051, effective January 21, 1994; amended at 18 Ill. Reg. 5934, effective April 1, 1994; amended at 18 Ill. Reg. 8718, effective June 1, 1994; amended at 18 Ill. Reg. 11231, effective July 1, 1994; amended at 19 Ill. Reg. 2905, effective February 27, 1995; emergency amendment at 19 Ill. Reg. 9280, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 11931, effective August 11, 1995; amended at 19 Ill. Reg. 15079, effective October 17, 1995; amended

at 20 Ill. Reg. 5068, effective March 20, 1996; amended at 20 Ill. Reg. 15993, effective December 9, 1996; emergency amendment at 21 Ill. Reg. 692, effective January 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 7423, effective May 31, 1997; amended at 21 Ill. Reg. 7748, effective June 9, 1997; amended at 21 Ill. Reg. 11555, effective August 1, 1997; amended at 21 Ill. Reg. 13638, effective October 1, 1997; emergency amendment at 22 Ill. Reg. 1576, effective January 5, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 7003, effective April 1, 1998; amended at 22 Ill. Reg. 8503, effective May 1, 1998; amended at 22 Ill. Reg. 16291, effective August 28, 1998; emergency amendment at 22 Ill. Reg. 16640, effective September 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19875, effective October 30, 1998; amended at 23 Ill. Reg. 2381, effective January 22, 1999; amended at 23 Ill. Reg. 11301, effective August 27, 1999; amended at 24 Ill. Reg. 7361, effective May 1, 2000; emergency amendment at 24 Ill. Reg. 10425, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15075, effective October 1, 2000; amended at 24 Ill. Reg. 18309, effective December 1, 2000; amended at 25 Ill. Reg. 8783, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 10533, effective August 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 16098, effective December 1, 2001; amended at 26 Ill. Reg. 409, effective December 28, 2001; emergency amendment at 26 Ill. Reg. 8583, effective June 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 9843, effective June 26, 2002; emergency amendment at 26 Ill. Reg. 11029, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 15051, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16288, effective October 25, 2002; amended at 27 Ill. Reg. 4708, effective February 25, 2003; emergency amendment at 27 Ill. Reg. 10793, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18609, effective November 26, 2003; amended at 28 Ill. Reg. 4701, effective March 3, 2004; amended at 28 Ill. Reg. 6139, effective April 1, 2004; emergency amendment at 28 Ill. Reg. 6610, effective April 19, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 7152, effective May 3, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11149, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12921, effective September 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13621, effective September 28, 2004; amended at 28 Ill. Reg. 13760, effective October 1, 2004; amended at 28 Ill. Reg. 14541, effective November 1, 2004; amended at 29 Ill. Reg. 820, effective January 1, 2005; amended at 29 Ill. Reg. 10195, effective June 30, 2005; amended at 29 Ill. Reg. 14939, effective September 30, 2005; emergency amendment at 30 Ill. Reg. 521, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 10314, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 15029, effective September 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 2629, effective January 28, 2007; emergency amendment at 31 Ill. Reg. 7323, effective May 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11667, effective August 1, 2007; amended at 31 Ill. Reg. 12756, effective August 27, 2007; emergency amendment at 31 Ill. Reg. 15854, effective November 7, 2007, for a maximum of 150 days; emergency rule suspended at 31 Ill. Reg. 16060, effective November 13, 2007; emergency rule repealed, effective May 10, 2008; peremptory amendment at 32 Ill. Reg. 7212, effective April 21, 2008; peremptory amendment suspended at 32 Ill. Reg. 8450, effective May 20, 2008; peremptory amendment repealed under Section 5-125 of the Illinois Administrative Procedure Act, effective November 16, 2008; amended at 32 Ill. Reg. 17428, effective November 1, 2008; peremptory amendment at 32 Ill. Reg. 18889, effective

November 18, 2008; peremptory amendment suspended at 32 Ill. Reg. 18906, effective November 19, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 33 Ill. Reg. 6551, effective April 28, 2009; peremptory amendment repealed by emergency rulemaking at 33 Ill. Reg. 6712, effective April 28, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 1681, effective February 1, 2009; amended at 33 Ill. Reg. 2289, effective March 1, 2009; emergency amendment at 33 Ill. Reg. 5802, effective April 2, 2009, for a maximum of 150 days; emergency expired August 29, 2009; emergency amendment at 33 Ill. Reg. 10785, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 12703, effective September 7, 2009; amended at 33 Ill. Reg. 15707, effective November 2, 2009; amended at 33 Ill. Reg. 17070, effective December 2, 2009; amended at 34 Ill. Reg. 889, effective December 30, 2009; emergency rulemaking at 34 Ill. Reg. 13538, effective September 1, 2010, for a maximum of 150 days; amended at 35 Ill. Reg. 379, effective December 27, 2010; amended at 35 Ill. Reg. 979, effective January 1, 2011; amended at 35 Ill. Reg. 18645, effective January 1, 2012.

SUBPART A: GENERAL PROVISIONS

Section 120.1 Incorporation by Reference

Any rules or regulations of an agency of the United States or of a nationally recognized organization or association that are incorporated by reference in this Part are incorporated as of the date specified, and do not include any later amendments or editions.

(Source: Added at 13 Ill. Reg. 3908, effective March 10, 1989)

SUBPART B: ASSISTANCE STANDARDS

Section 120.10 Eligibility for Medical Assistance

a) Eligibility for medical assistance exists when a person meets the non-financial requirements of the program and the person's countable nonexempt income (Sections 120.330 and 120.360) is equal to or less than the applicable Medical Assistance − No Grant (MANG) standard and, for AABD MANG, countable nonexempt resources are not in excess of the applicable resource disregards (Section 120.382). Persons receiving basic maintenance grants under Article III or IV of the Public Aid Code are eligible for medical assistance. Financial eligibility for medical assistance for other persons living in the community is determined according to Section 120.60 of this Part, unless otherwise specified. Financial eligibility for medical assistance for persons receiving long-term care services, as defined in Section 120.61(a) of this Part, is determined according to that Section, unless otherwise specified.

b) For AABD MANG, a person's countable income and resources include the person's countable income and resources and the countable income and resources of all persons included in the Medical Assistance standard. The person's responsible relatives living with the child must be included in the standard. The person has the option to request that a dependent child under age 18 in the home who is not included in the MANG unit be included in the MANG standard.

c) For TANF (Temporary Assistance for Needy Families) MANG, a person's countable income includes the person's nonexempt income and the nonexempt income of all persons included in the Medical Assistance standard. The person's responsible relatives living with the child must be included in the standard. The person has the option to request that a dependent child under age 18 in the home who is not included in the MANG unit be included in the MANG standard.

d) For AABD MANG, if a person's countable nonexempt income is greater than the applicable MANG standard and/or countable nonexempt resources are over the applicable resource disregard, the person must meet the spenddown obligation determined for the applicable time period before becoming eligible to receive medical assistance.

e) For TANF MANG, if a person's countable nonexempt income is greater than the applicable MANG standard, the person must meet the spenddown obligation determined for the applicable time period before becoming eligible to receive medical assistance.

f) A one month eligibility period is used for persons receiving long-term care services (as defined in Section 120.61(a) of this Part). Nonexempt income and

nonexempt resources over the resource disregard are applied toward the cost of care on a monthly basis, as provided in Section 120.61 of this Part.

g) Newborns

1) When the Department becomes aware of the birth of a child to a recipient of a TANF or AABD grant or related medical assistance or medical assistance due to the mother's pregnancy, the child shall be deemed to have applied for medical assistance only, without written request, if the mother had been receiving TANF or AABD related medical assistance or medical assistance due to her pregnancy on the date of birth of the child.

2) The newborn shall be eligible to receive medical assistance for a period of time as determined in Section 120.400.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.11 MANG(P) Eligibility

a) Pregnant Women Eligible for MANG(P)

1) Eligibility for medical assistance exists for a pregnant woman of any age who does not qualify as mandatory categorically needy (42 USC 1396a(a)(10)(A)(i)) who meets the following eligibility requirements:

A) cooperation in establishing eligibility as described in Section 120.308;

B) residency as described in Section 120.311; and

C) whose countable monthly income does not exceed the MANG(P) Income Standard (see Section 120.31).

2) The pregnant woman shall be eligible to receive medical assistance until 60 days following the last day of pregnancy. The 60 day medical coverage continues through the last day of the calendar month in which the 60 days period ends. The 60 day medical coverage period shall be provided for all women determined eligible for medical assistance under subsection (a)(1) of this Section including women who are no longer pregnant at the time of application, but were pregnant at any time during the three calendar months preceding the month in which the application was received. A woman who meets the requirements of this Section is eligible regardless of whether the pregnancy ended as a result of a birth, miscarriage or abortion and regardless of whether she signed an adoption agreement.

3) When a pregnant woman is determined eligible for medical assistance under subsection (a)(1) of this Section, income changes occurring after the eligibility determination are not considered through the 60 day postpartum period following the last day of pregnancy.

b) Children Under Age 19 Eligible for MANG(P)

1) Eligibility for medical assistance exists for children under age 19 who do not qualify as mandatory categorically needy (42 USC 1396a(a)(10)(A)(i)) who meet the following eligibility requirements:

A) cooperation in establishing eligibility as described in Section 120.308;

B) citizenship/alienage status as described in 120.310;

C) residency as described in Section 120.311; and

D) whose countable monthly income exceeds the MANG(C) or MANG(AABD) income standards (Sections 120.20 and 120.30) but does not exceed the MANG(P) income standard (see Section 120.31).

2) Children under age 19 shall be eligible to receive medical assistance under subsection (b)(1) of this Section for a period of time as determined in Section 120.400.

3) When the Department becomes aware of the birth of a child or children to a woman determined eligible under subsection (a)(1) of this Section while she was eligible, the child or children shall be deemed to have applied and been found eligible for medical assistance under subsection (b)(1) of this Section, without written request. The child or children shall be eligible to receive medical assistance for a period of time as determined in Section 120.400.

(Source: Amended at 24 Ill. Reg. 7361, effective May 1, 2000)

Section 120.12 Healthy Start – Medicaid Presumptive Eligibility Program For Pregnant Women

The purpose of the Healthy Start – Medicaid Presumptive Eligibility (MPE) Program is to encourage early and continuous prenatal care to low income pregnant women who otherwise may postpone or do without such care. Presumptively eligible pregnant women shall receive ambulatory prenatal care before completing an application for medical assistance under the State plan at the local Public Aid Office.

a) Eligibility: To be eligible for the Healthy Start – Medicaid Presumptive Eligibility Program, the woman must have:

1) a medically verified pregnancy; and

2) family income not exceeding 133% of the Federal Poverty Level.

b) Qualified providers shall make all determinations as to eligibility – the MPE Program (42 U.S.C. 1396).

c) The presumptive eligibility period shall be the period that:

1) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income does not exceed 133% of the Federal Poverty Level; and

2) ends with (and includes) the earlier of:

A) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan; or

B) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination, such last day.

d) Duties of the State agency, qualified providers, and presumptively eligible pregnant women.

1) The Department shall provide qualified providers with:

A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan; and

B) information on how to assist such women in completing and filing

such forms.

2) A qualified provider who determines that a pregnant woman is presumptively eligible for medical assistance under a State plan shall:

A) notify the Department of the determination within 5 working days after the date on which the determination is made; and

B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan by no later than the last day of the month following the month during which the determination is made.

3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan by no later than the last day of the month following the month during which the determination is made.

e) Ambulatory prenatal care consists of all outpatient medical care covered by the State plan.

(Source: Added at 15 Ill. Reg. 14240, effective September 23, 1991)

Section 120.14 Presumptive Eligibility for Children

a) A child younger than 19 years of age may be presumed eligible for medical assistance under this Part if all of the following apply:

1) an application for medical benefits has been made on behalf of the child;

2) the child is a resident of Illinois as described in Section 120.311;

3) the child is not an inmate of a public institution as described in Section 120.318(a);

4) the child's family's monthly income, as stated on the application, is at or below 133 percent of the poverty level;

5) the State employee who registers the application has no information that the child is not a U.S. citizen or a qualified non-citizen as described in Section 120.310 or 89 Ill. Adm. Code 118.500; and

6) the child has not been presumed eligible under this Part 120 or 89 Ill. Adm. Code 118 or 125 within the past 12 months.

b) Entities qualified to make a determination of presumptive eligibility include State employees involved in enrolling children in programs under this Part 120 or 89 Ill. Adm. Code 118 or 125.

c) The presumptive eligibility period begins on the date of application.

d) The presumptive eligibility period ends on the date the State's determination of the child's eligibility under this Part 120 or 89 Ill. Adm. Code 118 or 125 is updated in the data system.

(Source: Added at 28 Ill. Reg. 13621, effective September 28, 2004)

Section 120.20 MANG(AABD) Income Standard

The monthly countable income standard is 100 percent of the Federal Poverty Level Income Guidelines, as published annually in the Federal Register, for the appropriate family size.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.30 MANG(C) Income Standard

Number In Family	*Monthly Net Income*
1	283
2	375
3	508
4	558
5	650
6	733
7	767
8	808
9	850
10	900
11	942
12	992
13	1042
14	1100
15	1158
16	1217
17	1283
18	1350

a) If the number in the household unit exceeds the number provided above, add $67 for each additional person.

b) MANG(C) is available for a pregnant woman, of any age, who would be eligible for TANF or MANG(C) if the child had already been born. The pregnant woman and her spouse's income are combined and compared to the MANG standard for three persons.

c) If the case includes adults only, the MANG standard for one adult is $283. The standard for two adults is $375. An unborn child is counted as a family member.

d) When a child has earmarked income, other than State Supplemental Income (SSI), and the parent does not want this income applied to total family needs, the child is not to be included in the assistance unit. The family size used in the application of the MANG(C) Income Standards shall be reduced by one for each such child determined ineligible on this basis.

e) When financial eligibility for MANG(C) is being determined for one child only, the income of the child in excess of $283 a month is considered available to pay toward the child's medical expenses.

f) If eligibility is being determined for more than one child, the MANG(C) Standard for number of people shall be used.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

Section 120.31 MANG(P) Income Standard

a) MANG(P) is available to pregnant women and to children under age 19 who do not qualify as mandatory categorically needy (42 USC 1396a(a)(10)(A)(i)) whose non-exempt countable income does not exceed the MANG(P) income standard. If the household's countable monthly income exceeds the appropriate MANG(P) standards, eligibility for MANG(P) does not exist. The MANG(P) income standards are as follows:

1) The MANG(P) income standard shall be 200 percent of the current Federal Poverty Level Income Guidelines, as published annually in the Federal Register, for pregnant women and for infants born to women eligible for and receiving medical assistance on the date of the child=s birth, including women determined eligible for the date of birth pursuant to subsection (e)(4) of this Section.

2) The MANG(P) income standard shall be 133 percent of the current Federal Poverty Level Income Guidelines, as published annually in the Federal Register, for all other children under age 19.

b) MANG(P) is available for a pregnant woman, of any age, whose countable monthly income for the household does not exceed the MANG(P) income standard. If the pregnant woman is married and her spouse lives with her, her pregnancy does not make her spouse eligible for MANG(P). The pregnant woman and her spouse's income are combined and compared to the MANG(P) standard for the number of persons in the family even though only the pregnant woman is eligible to receive MANG(P). An unborn child is counted as a family member.

c) MANG(P) is available for children under age 19 whose countable monthly income for the household does not exceed the appropriate MANG(P) income standards.

d) When financial eligibility for MANG(P) is being determined for a child under age 19, the household's income is combined and compared to the MANG(P) income standard for the family size, including unborn children.

e) When financial eligibility for MANG(P) is being determined for a woman who meets the requirements for MANG(P), income is considered in the following manner:

1) Income is considered for the month of application. When eligibility exists for the month of application, MANG(P) coverage is authorized beginning with the month of application. Income changes occurring after the month

of application are not considered through the 60 day period following the last day of pregnancy.

2) Income is considered for the month following the month of application when the woman is income ineligible for the month of application. If eligibility exists for the month following the month of application, MANG(P) coverage is authorized beginning with the month following the month of application. Income changes occurring after the month following the month of application are not considered through the 60 day period following the last day of pregnancy.

3) When the case is income ineligible for the month of application and the month following the month of application, financial eligibility is determined under Sections 120.10 and 120.60.

4) When determining income eligibility for a backdated month (up to three months before the month of application), eligibility for medical coverage begins with the month income is at or below the MANG(P) income standard. Income changes occurring after the month of authorization are not considered through the 60 day period following the last day of pregnancy.

(Source: Amended at 24 Ill. Reg. 7361, effective May 1, 2000)

Section 120.32 FamilyCare Assist

a) A caretaker relative (see Section 120.390) who is 19 years of age or older qualifies for medical assistance when countable income is at or below the appropriate income standard.

b) The appropriate income standard is 133 per cent of the Federal Poverty Income Guidelines, as published annually in the Federal Register, for the appropriate family size.

(Source: Amended at 33 Ill. Reg. 15707, effective November 2, 2009)

Section 120.34 FamilyCare Share and FamilyCare Premium Level 1

a) A caretaker relative (see Section 120.390) who is 19 years of age or older qualifies for medical assistance when countable income is at or below the appropriate income standard.

b) The caretaker relative may not be otherwise eligible for medical assistance, including Section 120.32.

c) The appropriate income standard is 185 percent of the Federal Poverty Income Level Guidelines, as published annually in the Federal Register, for the appropriate family size. If income is greater than this amount, the Department shall compare it to the MANG(C) Income Standard in Section 120.30 to determine the spenddown amount.

d) Caretaker relatives will be enrolled into either FamilyCare Share or FamilyCare Premium Level 1 as follows:

1) If monthly countable income is above 133 percent and at or below 150 percent of the Federal Poverty Level (FPL) for the number of persons in the family, coverage under FamilyCare Share shall be effective as established in 89 Ill. Adm. Code 110.34.

2) If monthly countable income is above 150 percent and at or below 185 percent of the FPL for the number of persons in the family, an eligible caretaker relative shall be enrolled prospectively in FamilyCare Premium Level I and premiums shall be payable as established in subsection (f)(1) of this Section. Coverage for months prior to the first prospective month of coverage as established in 89 Ill. Adm. Code 110.34 shall be dependent on payment of premiums for those months as set forth in subsection (f)(2) of this Section.

3) The first month of prospective eligibility for caretaker relatives whose eligibility for FamilyCare Premium Level 1 is determined by the 15th of the month will be the following month. The first month of prospective eligibility for caretaker relatives whose eligibility for FamilyCare Premium Level 1 is determined after the 15th day of the month will be the second month following that determination.

e) Caretaker relatives enrolled in FamilyCare Premium Level 1 must pay monthly premiums based upon based upon the total number of adults in the family enrolled in FamilyCare Premium Level 1 and children in the family enrolled under 89 Ill. Adm. Code 125.240(c)(2).

1) The premium amounts are $15 for one person, $25 for two persons, $30 for three persons, $35 for four persons, and $40 for five or more persons.

2) Premiums are billed by and payable to the Department, or its authorized agent, on a monthly basis.

3) The premium due date will be the last day of the calendar month preceding the month of coverage.

4) No premiums will be charged to families with an enrolled person who is an American Indian or Alaska Native.

f) FamilyCare Premium Level 1 premiums shall be due as follows:

1) Premiums owed for the first prospective month of coverage and each subsequent month shall be due by the last day of the month preceding the month of coverage. Participants shall have a minimum grace period through the end of the month of coverage to pay the premium. Failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.

2) Coverage for the months of eligibility prior to the first prospective month of eligibility will not be authorized until the premium payment is received.

3) Partial premium payments will not be refunded.

g) An eligible caretaker relative becomes ineligible due to:

1) For those with countable income above 150 percent FPL, not paying the required premiums.

2) For those with countable income above 150 percent FPL, not repaying a rebate overpayment under 89 Ill. Adm. Code 125 to the Department, according to terms established by the Department, which may include recoupment out of future rebate payments or a payment plan.

h) Following termination of coverage under FamilyCare, the following action is required before the caretaker relative can be re-enrolled:

1) For caretaker relatives with countable income above 150 percent of the FPL, there must be full payment of premiums under Section 120.510 of FamilyCare, AllKids Premium Levels 1-8 under 89 Ill. Adm. Code 123 or 89 Ill. Adm. Code 125, Health Benefits for Workers with Disabilities under Section 120.510 of this Part, or Veterans Care under 89 Ill. Adm.

Code 128, for periods in which a premium was owed, including premiums owed when the caretaker relative was, for purposes of this Part, a member of another family;

2) For persons with countable income above 150 percent of the FPL, any overpayment of rebates must be repaid to the Department. A rebate overpayment shall be considered repaid if the Department can recoup the overpayment out of future rebate payments; and

3) The first month's premium must be paid if the caretaker relative is eligible for FamilyCare Premium Level 1 and there was an unpaid premium on the date the caretaker relative's previous eligibility was cancelled.

i) An application will be denied if any of the eligible caretaker relatives with income above 150 percent of the FPL in the family was responsible as a caretaker relative, or eligible as a caretaker relative during a period for which a premium under FamilyCare was due to the Department, and the premium remains unpaid at the time of application. That application shall be denied, regardless of whether the caretaker relative for whom the premium remains unpaid is included in the application.

(Source: Added at 33 Ill. Reg. 15707, effective November 2, 2009)

Section 120.40 Exceptions To Use Of MANG Income Standard MANG(AABD) (Repealed)

(Source: Repealed at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.50 AMI Income Standard (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

SUBPART C: FINANCIAL ELIGIBILITY DETERMINATION

Section 120.60 Community Cases

The following subsections apply to persons or family units who reside in the community or community-based residential facilities or settings (such as a Community Living Facility, Special Home Placement, Home Individual Program or Community and Residential Alternatives (59 Ill. Adm. Code 120.10).

a) The eligibility period shall begin with:

1) the first day of the month of application;

2) the first day of any month, prior to the month of application, in which the person meets financial and non-financial eligibility requirements up to three months prior to the month of application, if the person so desires; or

3) the first day of a month, after the month of application, in which the person meets non-financial eligibility requirements.

b) Eligibility Without Spenddown for MANG

1) For MANG AABD, if the person's countable income available during the eligibility period is equal to or below the applicable MANG AABD income standard (Section 120.20) and nonexempt resources are not in excess of the applicable resource disregard (Section 120.382), the person is eligible for medical assistance from the first day of the eligibility period. The Department will pay for covered services received during the entire eligibility period.

2) For TANF MANG, if the person's countable income available during the eligibility period is equal to or below the applicable MANG standard (Sections 120.20 and 120.30), the person is eligible for medical assistance from the first day of the eligibility period. The Department will pay for covered services received during the entire eligibility period.

3) The person is responsible for reporting any changes that occur during the eligibility period that might affect eligibility for medical assistance. If changes occur, appropriate action shall be taken by the Department, including termination of eligibility for medical assistance. If changes in income, resources or family composition occur that would make the person a spenddown case, a spenddown obligation will be determined and subsection (c) of this Section will apply.

4) A redetermination of eligibility will be made at least every 12 months.

c) Eligibility with Spenddown for MANG

1) For MANG AABD community cases, if the person's countable income available during the applicable eligibility period is greater than the applicable MANG AABD income standard and/or nonexempt resources are over the applicable resource disregard, the person must meet the spenddown obligation determined for the eligibility period before becoming eligible to receive medical assistance. The spenddown obligation is the amount by which the person's countable income exceeds the MANG AABD income standard and/or the amount of nonexempt resources in excess of the applicable resource disregard (see Section 120.384).

2) For TANF MANG, if a person's countable income available during the applicable eligibility period is greater than the applicable MANG standard (see Sections 120.20 and 120.30 of this Part), the person must meet the spenddown obligation determined for the eligibility period before becoming eligible to receive medical assistance. The spenddown obligation is the amount by which the person's countable income exceeds the MANG standard.

3) A person meets the spenddown obligation by incurring or paying for medical expenses in an amount equal to the spenddown obligation. Persons also have the option of meeting their income or resource spenddown by paying or having a third-party pay the amount of their spenddown obligation to the Department.

A) Incurred expenses are expenses for medical or remedial services:

i) recognized under State law;

ii) rendered to the person, the person's family, or a financially responsible relative;

iii) for which the person is liable in the current month for which eligibility is being sought or was liable in any of the 3-month retroactive eligibility period described in subsection (a) of this Section; and

iv) for which no third party is liable in whole or in part unless the third party is a State program.

B) Incurred medical expenses shall be applied to the spenddown obligation in the following order:

i) Expenses for necessary medical or remedial services, as funded by DHS or the Department on Aging from sources other than federal funds. The expenses shall be based on the service provider's usual and customary charges to the public. The expenses shall not be based on any nominal amount the provider may assess the person. These charges are considered incurred the first day of the month, regardless of the day the services are actually provided.

ii) Payments made for medical expenses within the previous six months. Payments are considered incurred the first day of the month of payment.

iii) Unpaid medical expenses. These are considered as of the date of service and are applied in chronological order.

C) If multiple medical expenses are incurred on the same day, the expenses shall be applied in the following order:

i) Health insurance deductibles (including Medicare and other co-insurance charges).

ii) All copayment charges incurred or paid on spenddown met day.

iii) Expenses for medical services and/or items not covered by the Department's Medical Assistance Program.

iv) Cost share amounts incurred for in-home care services by individuals receiving services through the Department on Aging (DonA).

v) Expenses incurred for in-home care services by individuals receiving or purchasing services from private providers.

vi) Expenses incurred for medical services or items covered by the Department's Medical Assistance Program. If more than one covered service is received on the day, the charges will be considered in order of amount. The bill for the smallest amount will be considered first.

D) If a service is provided during the eligibility period but payment may be made by a third party, such as an insurance company, the medical expense will not be considered towards spenddown until the bill is adjudicated. When adjudicated, that part determined to be the responsibility of the person shall be considered as incurred on the date of service.

E) AABD MANG spenddown persons may choose to pay or to have a third-party pay the amount of their spenddown obligation to the Department to meet spenddown. The following rules will govern when persons or third parties choose to pay the spenddown:

i) Payments to the Department will be applied to the spenddown obligation after all other medical expenses have been applied per subsections (c)(3)(A), (B) and (C) of this Section.

ii) Excess payments will be credited forward to meet the spenddown obligation of a subsequent month for which the person chooses to meet spenddown.

iii) The spenddown obligation may be met using a combination of medical expenses and amounts paid.

4) After application for medical assistance for cases eligible with a spenddown obligation that do not have a QMB or MANG(P) member, an additional eligibility determination will be made.

A) For TANF MANG, if countable income is greater than the income standard (Section 120.30), and for AABD MANG, if countable income is greater than the income standard or countable resources are greater than the resource disregard (Section 120.382(d)), a person will not be enrolled in spenddown unless:

i) the person does not have a spenddown obligation for any month of the 12-month enrollment period;

ii) medical expenses equal the spenddown obligation for at least one month of the 12-month enrollment period; or

iii) the person is on a waiting list or would be on a waiting list to receive a transplant if he or she had a source of payment.

B) Cases that meet any of these conditions will be notified, in writing,

of the spenddown obligation. The person will also be notified that his or her case will be reviewed beginning in the sixth month of the 12-month enrollment period. If the person has not had medical eligibility in one of the last three months at the time of review (including the month of review), the case will terminate unless the case contains a person who is on a waiting list or who would be on a waiting list to receive a transplant if he or she had a source of payment. A new application will be required if the person wishes continued medical assistance.

C) When proof of incurred medical expenses equal to the spenddown obligation is provided to the local office, eligibility for medical assistance shall begin effective the first day that the spenddown obligation is met. The Department will pay for covered services received from that date until the end of the eligibility period. The person shall be responsible, directly to the provider, for payment for services provided prior to the time the person meets the spenddown obligation.

5) Cases with a spenddown obligation that do not have a QMB, a MANG(P) member or a person on a waiting list or who would be on a waiting list to receive a transplant if he or she had a source of payment, will be reviewed beginning in the sixth month of enrollment to determine if they have had medical eligibility within the last three months, including the month of review. If so, enrollment will continue. If not, enrollment will be terminated and the person will be advised that if he or she wishes continued medical assistance, a reapplication must be filed. Upon reapplication, a new 12-month enrollment period will be established (assuming non-financial factors of eligibility are met). If appropriate, a new spenddown obligation will be created.

A) If the person files a reapplication prior to four months after the end of the period of enrollment, the person will be sent through a special abbreviated intake procedure making use of current case record material to verify factors of eligibility not subject to change.

B) Cases that remain eligible in the tenth month of the enrollment period or that have a QMB, a MANG(P) member or a person on a waiting list or who would be on a waiting list to receive a transplant if he or she had a source of payment, will remain enrolled and will be redetermined once every 12 months.

6) The person is responsible for reporting any changes that occur during the enrollment period that might affect eligibility for medical assistance. If

changes occur, appropriate action shall be taken by the Department, including termination of eligibility for medical assistance.

7) For MANG AABD, if changes in income, resources or family composition occur, appropriate adjustments to the spenddown obligation and date of eligibility for medical assistance shall be made by the Department. The person will be notified, in writing, of the new spenddown obligation.

A) If income decreases, or resources fall below the applicable resource disregard and, as a result, the person has already met the new spenddown obligation, eligibility for medical assistance shall be backdated to the appropriate date.

B) If income or resources increase and, as a result, the person has not produced proof of incurred medical expenses equal to the new spenddown obligation, the written notification of the new spenddown amount will also inform the person that eligibility for medical assistance will be interrupted until proof of medical expenses equal to the new spenddown obligation is produced.

8) For TANF MANG, if changes in income or family composition occur, appropriate adjustments to the spenddown obligation and date of eligibility for medical assistance shall be made by the Department. The person will be notified, in writing, of the new spenddown obligation.

A) If income decreases and, as a result, the person has already met the new spenddown obligation, eligibility for medical assistance shall be backdated to the appropriate date.

B) If income increases and, as a result, the person has not produced proof of incurred medical expenses equal to the new spenddown obligation, the written notification of the new spenddown amount will also inform the person that eligibility for medical assistance will be interrupted until proof of medical expenses equal to the new spenddown obligation is produced.

9) Reconciliation of Amounts Paid-in to Meet Spenddown

A) The Department will reconcile payments received to meet an income spenddown obligation for a given month against the amount of claims paid for services received in that month and refund any excess spenddown paid to the person. Excess amounts paid for a calendar month will be determined and refunded to the person six calendar quarters later. Refund payments will be made

once per quarter.

B) The Department will reconcile payments received to meet a resource spenddown obligation against the amount of all claims paid during the individual's period of enrollment for medical assistance. Excess amounts paid will be determined and refunded to the individual six calendar quarters after the individual's enrollment for medical assistance ends.

C) When payments are received to meet both a resource and an income spenddown obligation, the Department will first reconcile the amount of claims paid to amounts paid toward the resource spenddown. If the total amount of claims paid have not met or exceeded the amount paid to meet the resource spenddown by the time the individual's enrollment ends, the excess resource payments shall be handled per subsection (c)(3)(C) of this Section. Once the amount of claims paid equals or exceeds the amount paid toward the resource spenddown, the remaining amount of claims paid will be compared against the amount paid to meet the income spenddown per subsection (c)(3)(B) of this Section.

10) The Department will refund payment amounts received for any months in which the person is no longer in spenddown status and the payment cannot be used to meet a spenddown obligation. These payment amounts shall not be subject to reconciliation under subsection (c)(9) of this Section. Refunds shall be processed within six months after the case status changed.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.61 Long Term Care

This Section applies to persons residing in long term care facilities or State-certified, State-licensed, or State-contracted residential care programs who, as a condition of eligibility for medical assistance, are required to pay all of their income, less certain protected amounts, for the cost of their own care.

a) The term "long term care facility" refers to:

1) an institution (or a distinct part of an institution) that meets the definition of a "nursing facility" as that term is defined in 42 USC 1396r;

2) licensed Intermediate Care Facilities (ICF and ICF/DD), licensed Skilled Nursing Facilities (SNF and SNF/Ped) and licensed hospital-based long term care facilities (see 89 Ill. Adm. Code 148.50(c)); and

3) Supportive Living Facilities (SLF) and Community Integrated Living Facilities (CILA).

b) The eligibility period shall begin with:

1) the first day of the month of application;

2) up to three months prior to the month of application for any month in which the person meets both financial and non-financial eligibility requirements. Eligibility will be effective the first day of a retroactive month if the person meets eligibility requirements at any time during that month; or

3) the first day of a month, after the month of application, in which the person meets non-financial and financial eligibility requirements.

c) Eligibility Without Spenddown

1) A one-month eligibility period will be used. If a person's nonexempt income available during the eligibility period is equal to or below the applicable income standard and nonexempt resources are not in excess of the applicable resource disregard (see Section 120.382 of this Part), the person is eligible for medical assistance from the first day of the eligibility period without a spenddown.

2) A person eligible under this subsection (c) is responsible for reporting any changes that occur during the eligibility period that might affect eligibility for medical assistance. If changes occur, appropriate action shall be taken

by the Department, including termination of eligibility for medical assistance. If changes in income, resources or family composition occur that would make the person a spenddown case, a spenddown obligation will be determined and subsection (d) of this Section will apply. A redetermination of eligibility shall be made at least every 12 months.

d) Eligibility with Spenddown

1) If countable income available during the eligibility period exceeds the applicable income standard and/or nonexempt resources exceed the applicable resource disregard, a person has a spenddown obligation that must be met before financial eligibility for medical assistance can be established. The spenddown obligation is the amount by which the person's countable income exceeds the applicable income standard or nonexempt resources exceed the applicable resource disregard.

2) A person meets the spenddown obligation by incurring or paying for medical expenses in an amount equal to the spenddown obligation. Medical expenses shall be applied to the spenddown obligation as provided in Section 120.60(c) of this Part.

3) Projected expenses for services provided by a long term care facility that have not yet been incurred, but are reasonably expected to be, may also be used to meet a spenddown obligation. The amount of the projected expenses is based on the private pay rate of the long term care facility at which the person resides or is seeking admission.

4) A person who has both an income spenddown and a resource spenddown cannot apply the same incurred medical benefits to both. Incurred medical expenses are first applied to an income spenddown.

e) Post-eligibility Treatment of Income. If non-financial and financial eligibility is established, a person's total income, including income exempt and disregarded in determining eligibility, must be applied to the cost of the person's care, minus any applicable deductions provided under subsection (f) of this Section.

f) Post-eligibility Income Deductions. From a person's total income that is payable for a person's care, certain deductions are allowed. Allowed deductions shall increase the amount paid by the Department for residential services on behalf of the person, up to the Department's payment rate for the facility. Deductions shall be allowed for the following amounts in the following order:

1) SSI benefits paid under 42 USC 1382(e)(1)(E) or (G) and, for residents of Supportive Living Facilities, the minimum current SSI payment standard

for an individual (or a couple, if spouses reside together), less the personal needs allowance specified in subsection (f)(2)(C) of this Section, shall be deducted for room and board charges (see 89 Ill. Adm. Code 146.225(c) and (d));

2) a personal needs allowance:

A) for persons other than those specified in subsections (f)(2)(B) through (E), $30 per month;

B) for spouses residing together, $60 per couple per month ($30 per spouse);

C) for persons or spouses residing in Supportive Living Facilities, $90;

D) for persons residing in Community Integrated Living Arrangements (see 59 Ill. Adm. Code 115), $50; or

E) for veterans who have neither a spouse nor dependent child, or surviving spouses of veterans who do not have a dependent child, and whose monthly veterans' benefits are reduced to $90, a $90 income disregard is allowed in lieu of a personal allowance deduction. Persons allowed the $90 per month income disregard are not also permitted the $30 per month personal allowance;

3) a community spouse income allowance pursuant to Section 120.379(e) of this Part;

4) a family allowance pursuant to Section 120.379(e)(2) of this Part;

5) an amount to meet the needs of qualifying children (as defined in 26 USC 152) under age 21 who do not reside with either parent, who do not have enough income to meet their needs and whose resources do not exceed the resource limit. To determine needs and resource limits:

A) the MANG(C) and applicable resource disregard are used (see Sections 120.30 and 120.382 of this Part); and

B) any payments made on medical bills for the children can be deducted from the person's income;

6) amounts for incurred expenses for certain Medicare and health insurance cost sharing that are not subject to payment by a third party, limited to:

A) Medicare premiums, deductibles, or coinsurance charges not paid by Medicaid or another third party payor;

B) Other health insurance premiums, deductibles or coinsurance (cost sharing) charges provided the insurance meets the definition of a "health benefit plan" and is approved for providing that insurance in Illinois by the Illinois Department of Insurance.

i) "Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

ii) Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance (except for the month of admission to a long term care facility); dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

7) Expenses Not Subject to Third Party Payment for Necessary Medical Care Recognized under State Law, but Not a Covered Service under the Medical Assistance Program. "Necessary medical care" has the meaning described in 215 ILCS 105/2 and must be proved as such by a prescription, referral or statement from the patient's doctor or dentist. The following are allowable deductions from a person's post-eligibility income for medically necessary services:

A) expenses incurred within the six months prior to the month of an application, provided those expenses remain a current liability to the person and were not used to meet a spenddown. Medical expenses incurred during a period of ineligibility resulting from a penalty imposed under Section 120.387 or 120.388 of this Part are not an allowable deduction;

B) expenses incurred for necessary medical services from a medical

provider (subject to reasonable dollar limits on specific services) so long as the provider was not terminated, barred or suspended from participation in the Medical Assistance Program (pursuant to 89 Ill. Adm. Code 140.16, 140.17 or 140.18) at the time the medical services were provided; and

C) expenses for long term care services, subject to the limitations of this subsection (f)(7) and provided that the services were not provided by a facility to a person admitted during a time the facility was subject to the sanction of non-payment for new admissions (see 305 ILCS 5/12-4.25(I)(3));

8) Amounts to maintain a residence in the community for up to six months when:

A) the person does not have a spouse and/or dependent children in the home;

B) a physician has certified that the stay in the facility is temporary and the individual is expected to return home within six months;

C) the amount of the deduction is based on:

i) the rent or property expense allowed under the AABD MANG standard if the person was at home (see 89 Ill. Adm. Code 113.248); and

ii) the utility expenses that would be allowed under the AABD MANG standard if the person was at home (see 89 Ill. Adm. Code 113.249).

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section l20.62 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings Under 89 Ill. Adm. Code 140.643 (Repealed)

(Source: Repealed at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.63 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings (Repealed)

(Source: Repealed at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.64 MANG(P) Cases

a) The following subsections apply to MANG(P) clients. The eligibility period for a MANG(P) client shall begin with:

1) the first day of the month of application; or

2) the first day of any month prior to the month of application if the client so desires up to three months prior to the month of application; or

3) the first day of the month after the month of application; or

4) the first day of a month a pregnant woman and/or child under age 19 meets the requirements of Sections 120.11 and 120.31.

b) The pregnant woman shall be eligible to receive medical assistance until 60 days following the last day of pregnancy. The 60 day medical coverage continues through the last day of the calendar month in which the 60 day period ends. The 60 day medical coverage period shall be provided for all women determined eligible for medical assistance under Section 120.11(a)(1) of this Section including women who are no longer pregnant at the time of application because the woman gave birth or had a miscarriage or an abortion, and including women who signed an adoption agreement.

c) Children shall be eligible to receive medical assistance as determined pursuant to Section 120.400.

d) Covered services received during the entire eligibility period will be paid by the Department (see 89 Ill. Adm. Code 140.3).

e) A redetermination of eligibility for MANG(P) will be made every 12 months for children under age 19.

f) The client is responsible to report any changes that occur during the eligibility period which might affect eligibility for MANG(P). If changes in income or family composition occur which would make the client ineligible for MANG(P), appropriate action shall be taken by the Department, including evaluation of eligibility for other programs or termination of eligibility for medical assistance. Income changes occurring after a pregnant woman is determined eligible for MANG(P) coverage are not considered through the 60 day postpartum period following the last day of pregnancy.

g) MANG(P) clients shall be eligible without a spenddown obligation amount.

h) A review of case eligibility for MANG(C) will be conducted for a pregnant woman during the second month of the 60 day extended medical coverage period. If eligible, the case shall be transferred by the Department to the appropriate program without interruption in benefit eligibility. If ineligible, the Department shall notify the client in writing.

i) A review of case eligibility for TANF MANG(C) will be conducted when a child is determined ineligible for MANG (P). If the child is eligible for TANF MANG(C), the case shall be transferred by the Department without interruption in benefit eligibility. If ineligible, written notification shall be provided to the client.

(Source: Amended at 24 Ill. Reg. 7361, effective May 1, 2000)

Section 120.65 Department of Mental Health and Developmental Disabilities (DMHDD) Licensed Community-Integrated Living Arrangements (Repealed)

(Source: Repealed at 35 Ill. Reg. 18645, effective January 1, 2012)

SUBPART D: MEDICARE PREMIUMS

Section 120.70 Supplementary Medical Insurance Benefits (SMIB) Buy-In Program

a) The Department shall pay the premium for Supplementary Medical Insurance benefits (SMIB) (Part B of Medicare) for specified clients in accordance with the buy-in agreement with the Social Security Administration (SSA) and the Medicare Catastrophic Coverage Act of l988 (P.L. 100-360). Individuals may previously have enrolled in SMIB themselves or they will be enrolled by the Department.

b) Eligible Individuals

1) The Department shall pay the SMIB premium for the following individuals:

A) individuals who receive financial assistance (including zero grant) under the AABD or AFDC program;

B) individuals who, except for the Social Security benefit increase of l972 (42 CFR 435.134), would still be eligible to receive cash assistance as an aged, blind or disabled person (89 Ill. Adm. Code 113) and who are eligible for both SMIB and the Department's Medicaid program (89 Ill. Adm. Code 120);

C) individuals with Supplemental Security Income (SSI) income who receive full Medicaid benefits under the AABD program; and

D) Qualified Medicare Beneficiaries (QMB)s (see Section l20.72).

E) Specified Low-Income Medicare Beneficiaries (SLIB)s (see Section 120.73).

2) Individuals who qualify under subsections (b)(l)(A) thru (b)(1)(C) above may include individuals not eligible for Part A of Medicare (see Title XVIII of the Social Security Act).

c) Beginning Eligibility

1) Individuals who qualify under subsections (b)(l)(A), (b)(1)(B) or (b)(1)(C) shall be added to the SMIB Buy-in Program for the first month in which they are eligible for both SMIB enrollment and medical assistance. Recipients shall remain in the Buy-in Program while in $0 grant status and for any month in which they qualify under (b)(l)(A) thru (b)(1)(D) above.

2) Individuals who qualify under subsection (b)(1)(D) shall be added to the SMIB Buy-in Program for the first month following the month in which they are determined eligible for QMB status. Recipients shall remain in the SMIB Buy-in Program for any month in which they qualify under subsection (b)(l)(A) thru (b)(1)(D) above.

3) Individuals who qualify under subsection (b)(1)(E) may be added to the SMIB Buy-in Program effective three months prior to the month of application for SLIB benefits only or SLIB benefits and medical assistance.

(Source: Amended at 17 Ill. Reg. 6827, effective April 21, 1993)

Section 120.72 Eligibility for Medicare Cost Sharing as a Qualified Medicare Beneficiary (QMB)

a) Eligibility for Medicare cost sharing exists for Qualified Medicare Beneficiaries (QMB)s. A QMB is an individual who:

l) is a beneficiary of Medicare Part A (i.e. Hospital Insurance);

2) meets the general non-financial factors of eligibility for the Medicaid Program (see Sections l20.3l0, l20.3ll, l20.3l9 and l20.325);

3) has countable monthly income which does not exceed the QMB income standard (see Section l20.74); and

4) has countable assets which do not exceed the QMB asset disregard (see Section l20.382(d)).

b) When considering Social Security Benefits, the monthly amount to consider for January through the month following the month in which the annual Federal Poverty Level amounts are announced will not include the annual Retirement Survivors Disability Insurance (RSDI) Cost of Living Adjustment (COLA). For all other months of the year the full amount of RSDI benefits will be considered.

c) QMBs may be eligible for the full range of Medicaid services (see 89 Ill. Adm. Code 140) only if they meet all eligibility requirements for Medicaid (see 89 Ill. Adm. Code 120).

d) Eligibility for Medicare cost sharing is effective the first day of the month following the QMB eligibility determination.

e) QMBs are eligible for Medicaid payment of Medicare cost sharing expenses (i.e., Part A and Part B premiums, deductibles and coinsurance (See Title XVIII of the Social Security Act.)) in accordance with Sections l20.70, l20.76 and 89 Ill. Adm. Code l40.2l.

f) Eligibility for QMB status will be redetermined at least every twelve (l2) months.

(Source: Amended at 15 Ill. Reg. 5302, effective April 1, 1991)

Section 120.73 Eligibility for Medicaid Payment of Medicare Part B Premiums as a Specified Low-Income Medicare Beneficiary (SLIB)

a) Eligibility for Medicaid payment of Medicare Part B premiums exists for Specified Low-Income Medicare Beneficiaries (SLIB)s. A SLIB is an individual who:

l) is a beneficiary of Medicare Part A (i.e. Hospital Insurance);

2) meets the general non-financial factors of eligibility for the Medicaid Program (see Sections 120.310, 120.311, 120.319 and 120.325);

3) has countable monthly income which exceeds the Qualified Medicare Beneficiary (QMB) income standard (see Section 120.74), but is less than or equal to the SLIB income standard (see Section 120.75); and

4) has countable assets which do not exceed the QMB asset disregard (see Section 120.382(d)).

b) When considering Social Security Benefits, the monthly amount to consider for January through the month following the month in which the annual Federal Poverty Level (FPL) amounts are announced will not include the annual Retirement Survivors Disability Insurance (RSDI) Cost of Living Adjustment (COLA). For all other months of the year the full amount of RSDI benefits will be considered.

c) SLIBs with incomes from 100 percent of the FPL up to 120 percent of the FPL may be eligible for the full range of Medicaid services (see 89 Ill. Adm. Code 140) only if they meet all eligibility requirements for Medicaid (see 89 Ill. Adm. Code 120).

d) Individuals with incomes of at least 120 percent of the FPL but less than 175 percent of the FPL, who receive Medicaid benefits, are not eligible for the benefits described in subsection (g) of this Section.

e) Eligibility for Medicaid Payment of Medicare Part B premiums may be effective up to three months prior to the month of application.

f) Eligibility for SLIB status will be redetermined at least every 12 months.

g) SLIBs with incomes from 100 percent of the FPL up to 135 percent of the FPL are eligible for Medicaid payment of Medicare Part B premiums (see Title XVIII of the Social Security Act), in accordance with Sections 120.70 and 89 Ill. Adm. Code 140.21. Individuals with incomes from 135 percent of the FPL up to 175

percent of the FPL are not eligible for Medicaid payment of Part B Medicare premiums. These persons are only eligible for a monthly payment that is for the portion of Medicare cost sharing described in the Social Security Act (U.S.C. 1905(p)(3)(A)(ii)).

(Source: Amended at 22 Ill. Reg. 8503, effective May 1, 1998)

Section 120.74 Qualified Medicare Beneficiary (QMB) Income Standard

The QMB income standard is equal to a percentage of the then current Federal Poverty Level Income Guidelines as published annually in the Federal Register) for the size of the household. If the household's countable monthly income (see 89 Ill. Adm. Code 112, 113, 120) exceeds the QMB income standard, eligibility for QMB status does not exist. The timetable for the applicable percentage is as follows:

January – December 1989	80%
January – December 1990	85%
January – December 1991	95%
January – December 1992	100%

(Source: Amended at 15 Ill. Reg. 5302, effective April 1, 1991)

Section 120.75 Specified Low-Income Medicare Beneficiary (SLIB) Income Standards

The SLIB income standards are equal to a percentage of the then current Federal Poverty Level (FPL) Income Guidelines as published annually in the Federal Register for the size of the household. If the household's countable monthly income (see 89 Ill. Adm. Code 112, 113, 120) exceeds the appropriate SLIB income standard, eligibility for SLIB status does not exist. The applicable percentages are as follows:

a) Effective January 5, 1998, the SLIB income standard is at least 100 percent of the FPL, but less than 135 percent of the FPL.

b) Effective January 5, 1998, persons with incomes that are at least 135 percent of the FPL but less than 175 percent of the FPL, may receive the special monthly payment described in Section 120.73(g).

(Source: Amended at 22 Ill. Reg. 8503, effective May 1, 1998)

Section 120.76 Hospital Insurance Benefits (HIB)

a) The Department shall pay the Hospital Insurance Benefit (HIB) (Part A of Medicare) premium for Qualified Medicare Beneficiaries (QMBs) (see Section l20.72). Payments will be made in behalf of QMBs who have individually enrolled for HIB with the Social Security Administration and who are charged a HIB premium.

b) The Department will pay the HIB premium beginning the month following the month of the QMB eligibility determination. Payment will continue as long as the individual retains QMB status.

(Source: Amended at 14 Ill. Reg. 7637, effective May 10, 1990)

SUBPART E: RECIPIENT RESTRICTION PROGRAM

Section 120.80 Recipient Restriction Program

a) The Recipient Restriction Program (RRP) shall identify recipients who unnecessarily utilize medical services. When the Department determines, on the basis of statistical norms and the medical judgment of physicians and/or pharmacologists, that a Medicaid recipient has received medical services that are not medically necessary based on the recipient's diagnoses and/or medical condition or conditions or in such a manner as to constitute an abuse of medical privileges, the decision to restrict a recipient to a Primary Care Provider and/or Primary Care Pharmacy will be made. RRP applies to all medical assistance programs administered by the Department.

b) Primary and Secondary Sources of Recipient Identification

1) The primary source of recipient identification shall be the Surveillance and Utilization Review Subsystem (SURS) of the Medicaid Management Information System (MMIS). On a quarterly basis, SURS analyzes the entire Medicaid population, determines medical usage per recipient and will identify recipients with usages in excess of the quarterly established norm of recipients in the same category of assistance and like demographic areas.

2) Secondary sources of identification shall be incoming referrals, such as referrals from medical providers, law enforcement officials or members of the general public. All referrals shall be reviewed and analyzed. Recipients found to have loaned or altered their medical cards for the purpose of obtaining medical benefits for which they or other persons are not legitimately entitled; falsely represented medical coverage; found in possession of blank or forged prescription pads; or who knowingly assisted providers in rendering excessive services or defrauding the Medical Assistance Program shall be restricted.

c) Once a recipient is identified, medical usage based on diagnoses and/or medical condition for the nine months preceding identification shall be reviewed. Medical Assistance Consultants, licensed physicians and/or pharmacologists will determine if the recipient should be restricted due to the medical services received being not medically necessary. The Department shall initially designate, without regard to choice, a Primary Care Provider and/or Primary Care Pharmacy. The Department's designation shall remain in effect for the entire period of the restriction unless the recipient changes this designation pursuant to subsection (f) of this Section. Each recipient to be restricted will be notified in writing. This notice will also contain a statement relating to the medical necessity of services

consistent with the findings of the professional consultants; a statement advising the recipient of his or her right to appeal; and a toll-free number to call for information.

d) Department Designated Primary Care Provider and/or Primary Care Pharmacy

1) The Department will select one provider and/or one pharmacy in reasonable geographical proximity to the recipient's home to serve as the recipient's Primary Care Provider and/or Primary Care Pharmacy.

2) The primary care physician shall be a medical doctor or doctor of osteopathy, licensed to practice medicine in all its branches, or a clinic enrolled to provide primary care; a properly registered Medicaid provider in good standing with the Department per the physician registration; enrolled to provide physician services with the Department; and willing to serve as the primary care provider.

e) Types of Services Provided or Authorized

1) Once restricted, the Recipient Eligibility Verification (REV) system shall display information regarding the Primary Care Provider and/or Primary Care Pharmacy. REV will also display information that emergency services will not be restricted. If restricted to a Primary Care Provider, the Primary Care Provider must provide or authorize the following non-emergency ambulatory care services for the restricted recipient before the Department will render payment for the services:

A) Clinic

B) Laboratory

C) Outpatient Hospital

D) Pharmacy

E) Physician

2) The Primary Care Pharmacy must supply all prescriptions. Authorization to obtain non-emergency prescriptions from any other source will only be approved in such instances when a specific item is not part of the Primary Care Pharmacy's inventory and cannot be acquired through the Primary Care Pharmacy.

3) Other covered services may be provided by a qualified provider in the

Department's Medical Program.

f) Changing the Designated Primary Care Provider and/or Primary Care Pharmacy

1) The recipient may change the Department's initial designation of a Primary Care Provider or Primary Care Pharmacy once without cause. The request for change must be submitted to the Department in writing. The Department, by notice, shall inform the recipient how to request a change in Primary Care Provider or Primary Care Pharmacy.

2) The recipient may change his or her designated provider for cause if one of the following circumstances is verified:

A) Change of recipient's residence from the geographic area of the Primary Care Provider or Primary Care Pharmacy;

B) Change in the recipient's medical condition which the Primary Care Provider is unable to treat or refer to another provider;

C) Death of the Primary Care Provider;

D) Disenrollment of the Primary Care Provider and/or Primary Care Pharmacy from the Medical Assistance Program; and

E) Notice from the Primary Care Provider and/or Primary Care Pharmacy that they will no longer serve as the Primary Care Provider.

3) The Department will notify the recipient in writing if the Primary Care Provider and/or Primary Care Pharmacy has disenrolled as a provider of Medicaid services or if the provider notifies the Department of their unwillingness to continue to serve as the recipient's Primary Care Provider.

4) Changes in designated Primary Care Provider and/or Primary Care Pharmacy shall be processed effective with the earliest possible date reflected on the eligibility file.

5) For the provider or pharmacy, the Department will determine if the requested change meets the criteria in subsection (d) of this Section.

g) Length of Restriction

1) Once recipients are restricted they remain in restriction for a minimum of

four full quarters. If restricted recipients transfer to a different assistance unit, the restriction will be processed to follow the recipient. If a restricted recipient becomes inactive and is subsequently reactivated, the restriction will be reactivated until such time as four full quarters have elapsed.

2) Reevaluation of the Recipient's Medical Usage

A) When a recipient has had his or her medical card restricted for four full quarters, the Department shall reevaluate the recipient's medical usage to determine whether the recipient continues to receive medical services that are not medically necessary. The Department shall evaluate each case not later than eighteen months after the effective date of restriction. If the recipient is still receiving medical services that are not medically necessary, the restriction shall be continued for an additional period of eight full quarters. This additional period of eight full quarters shall begin with the first month immediately following the end of the first four full quarter restriction period. If the recipient no longer is receiving medical services that are not medically necessary, the restriction shall be discontinued. A "quarter", for purposes of this Section, shall be defined as one of the following three-month periods of time: January-March, April-June, July-September or October-December.

B) If necessary to determine if medical services that are not medically necessary are still being received, the Department shall obtain a complete copy of the recipient's medical record from the Primary Care Provider. The medical record will be reviewed by the Medical Assistant Consultant with a final determination by a licensed physician and/or pharmacologist to determine if the medical services received were medically necessary.

C) If the decision is to release the recipient from restriction, such release will be processed effective with the earliest possible date reflected on the eligibility file.

D) If the services are determined to be medically unnecessary, the recipient will be notified in writing of the continued restriction. The Department may designate a different Primary Care Physician and/or Primary Care Pharmacy. The criteria in subsection (d) of this Section shall apply. This notice will also contain a statement relating to the medical necessity of services consistent with the findings of the professional consultants; a statement advising the recipient of his or her right to appeal; and a toll-free number to call

for information.

3) If the restriction is continued, a review will be conducted in accordance with subsection (g)(2) of this Section, subsequent to the additional eight quarter period.

4) A recipient who has been restricted under this Section, is released and then is restricted under this Section a subsequent time, shall be restricted for a period of eight full quarters. Subsequent to this eight quarter period, a review will be conducted in accordance with subsection (g)(2) of this Section.

h) Recipients have the right to appeal inclusion in the program. (See 89 Ill. Adm. Code 102.80 through 102.84.)

i) Any recipient in the RRP is not permitted to enroll in a Managed Care Organization (MCO).

j) Any recipient designated by the Department for restriction in the RRP who is, at that time, enrolled in an MCO will be disenrolled from the MCO upon the RRP designation.

(Source: Amended at 28 Ill. Reg. 14541, effective November 1, 2004)

SUBPART F: MIGRANT MEDICAL PROGRAM

Section 120.90 Migrant Medical Program (Repealed)

(Source: Repealed at 24 Ill. Reg. 18309, effective December 1, 2000)

Section 120.91 Income Standards (Repealed)

(Source: Repealed at 24 Ill. Reg. 18309, effective December 1, 2000)

SUBPART G: AID TO THE MEDICALLY INDIGENT

Section 120.200 Elimination Of Aid To The Medically Indigent

Effective August 1, 1991, the Aid to the Medically Indigent Program (AMI) was eliminated pursuant to Public Act 87-14. Any references to the AMI program contained in the Department's rules are obsolete and of no effect as of August 1, 1991.

(Source: Added at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.208 Client Cooperation (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.210 Citizenship (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.211 Residence (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.212 Age (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.215 Relationship (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.216 Living Arrangement (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.217 Supplemental Payments (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.218 Institutional Status (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.224 Foster Care Program (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.225 Social Security Numbers (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.230 Unearned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.235 Exempt Unearned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.236 Education Benefits (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.240 Unearned Income In-Kind (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.245 Earmarked Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.250 Lump Sum Payments and Income Tax Refunds (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.255 Protected Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.260 Earned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.261 Budgeting Earned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.262 Exempt Earned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.270 Recognized Employment Expenses (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.271 Income From Work/Study/Training Program (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.272 Earned Income From Self-Employment (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.273 Earned Income From Roomer and Boarder (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.275 Earned Income In-Kind (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.276 Payments from the Illinois Department of Children and Family Services (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.280 Assets (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.281 Exempt Assets (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.282 Asset Disregards (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.283 Deferral of Consideration of Assets (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.284 Spend-down of Assets (AMI) (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.285 Property Transfers (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.290 Persons Who May Be Included in the Assistance Unit (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.295 Payment Levels for AMI (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

SUBPART H: MEDICAL ASSISTANCE – NO GRANT (MANG) ELIGIBILITY FACTORS

Section 120.308 Client Cooperation

a) As a condition of eligibility, clients must cooperate:

1) in the determination of eligibility;

2) with Department programs conducted for the purposes of acquisition or verification of information upon which eligibility may depend; and

3) in applying for all financial benefits for which they may qualify and to avail themselves of those benefits at the earliest possible date.

b) Clients are required to avail themselves of all potential income and resources and to take appropriate action to receive such resources, including those described under Section 120.388(d)(2) of this Part.

c) When eligibility cannot be conclusively determined because the individual is unwilling or fails to provide essential information or to consent to verification, the client is ineligible.

d) At screening, applicants shall be informed, in writing, of any information they are to provide at the eligibility interview.

e) At the eligibility interview or at any time during the application process, when the applicant is requested to provide information in his or her possession, the Department will allow 10 days for the return of the requested information. The first day of the 10 day period is the calendar day following the date the information request form is sent or given to the applicant. The last day of the 10 day period shall be a work day and is to be indicated on the information request form. If the applicant does not provide the information by the date on the information request form, the application shall be denied on the following work day.

f) At the eligibility interview or at any time during the application process, when the applicant is requested to provide third party information, the Department shall allow 10 calendar days for the return of the requested information or for verification that the third party information has been requested. The first day of the 10 day period is the calendar day following the date the information request form is sent or given to the applicant. The last day of the 10 day period shall be a work day and will be indicated on the information request form. If the applicant does not provide the information or verification that the information was requested by the date on the information request form, the application shall be

denied on the following work day.

1) Third party information is defined as information that must be provided by someone other than the applicant. An authorized representative or person applying on another's behalf is not a third party, but is treated as if he or she were the applicant.

2) The Department shall advise clients of the need to provide written verification of third party information requests and the consequences of failing to provide that verification.

3) If the applicant requests an extension either verbally or in writing in order to obtain third party information and provides written verification of the request for the third party information, such as a copy of the request that was sent to the third party, an extension of 45 days from the date of application shall be granted. The first day of the 45 day period is the calendar day following the date of application. The 45th day must be a work day.

4) If an applicant's attempt to obtain third party information is unsuccessful, upon the applicant's request, the Department will assist in securing evidence to support the client's eligibility for assistance.

g) Any information or verifications requested under this Section must be returned to the Department's or its agent's office in the manner indicated on the information request form. Information mailed or otherwise delivered to an address not indicated on the form will not toll the timeframes for providing information under this Section.

h) Failure to cooperate in the determination of eligibility under this Section, including failure to provide requested information or verifications, is a basis for the denial of an application for benefits. A person has the right to appeal such a denial under 89 Ill. Adm. Code 102.80. The Department shall not deny an application if third party information cannot be timely obtained when the delay is beyond the control of the person and a timely request was made to the third party for the information. The Department shall not deny an application for failure to timely provide information in the applicant's possession if the person has made a good faith attempt to retrieve the information and is unable, due to incapacity, illness, family emergency or other just cause, to do so.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.309 Caretaker Relative

a) The caretaker relative is the specified relative with whom the child is living. When a dependent child lives with a parent that parent shall be designated as the caretaker relative.

b) Every MANG(C) case shall have one person designated as the caretaker relative. The caretaker relative does not have to meet a minimum or a maximum age requirement and if the caretaker relative is included in the assistance unit, this person shall no longer be considered a dependent child. No person shall serve as caretaker relative for more than one AFDC grant case at the same time, except for an AFDC-U parent whose child's eligibility is based on the lack of parental support or care of that child's other parent.

c) An exception to the above shall occur when no specified relative is immediately available to act as a caretaker relative. (In this situation, another person may serve as a Temporary Caretaker for a period not to exceed 90 days.) "Living with" requirements of the child(ren) are the same as with a caretaker relative. The Temporary Caretaker will not be included in the assistance unit.

(Source: Added (by codification with no substantive change) at 7 Ill. Reg. 16108)

Section 120.310 Citizenship

To be eligible for assistance, an individual shall be either a United States (U.S.) citizen or a non-citizen within specific categories and subject to specific restrictions set forth in subsection (a) and (b).

a) Citizenship status – Persons born in the U.S., or in its possessions, are U.S. citizens. Citizenship can also be acquired by naturalization through court proceedings, or by certain persons born in a foreign country of U.S. citizen parents.

b) Non-citizens

1) The following categories of non-citizens may receive assistance, if otherwise eligible:

A) A U.S. veteran honorably discharged and a person on active military duty, and the spouse and unmarried dependent children of that person;

B) Refugees under section 207 of the Immigration and Nationality Act (INA);

C) Asylees under section 208 of INA;

D) Persons for whom deportation has been withheld under section 243(h) of INA;

E) Persons granted conditional entry under section 203(a)(7) of INA as in effect prior to April 1, 1980;

F) Persons lawfully admitted for permanent residence under INA;

G) Parolees, for at least one year, under section 212(d)(5) of INA;

H) Nationals of Cuba or Haiti;

I) Persons identified by the Federal Office of Refugee Resettlement (ORR) as victims of trafficking;

J) Amerasians from Vietnam;

K) Members of the Hmong or Highland Laotian tribe when the tribe

helped U.S. personnel by taking part in a military or rescue operation during the Vietnam era;

L) American Indians born in Canada; and

M) Persons who are a spouse, widow or child of a U.S. citizen or a spouse or child of a legal permanent resident (LPR) who have been battered or subjected to extreme cruelty by the U.S. citizen or LPR or a member of that relative's family who lived with them, who no longer live with the abuser or plan to live separately within one month of assistance and whose need for assistance is due, at least in part, to the abuse.

2) Those persons who are in the category set forth in subsection (b)(1)(F) of this Section, who enter the United States on or after August 22, 1996, shall not be eligible for five years beginning on the date the person entered the United States, with the exception of Iraqi and Afghan special immigrants under section 101(a)(27) of INA (8 USC 1101(a)(27)). Iraqi and Afghan special immigrants are eligible for a limited period of time established by the federal government. The limited time period begins with either the date the person entered the United States as a special immigrant or the date his or her status was adjusted within the United States.

3) Those persons who are in the category set forth in subsection (b)(1)(G) of this Section, who enter the United States on or after August 22, 1996, shall not be eligible for five years beginning on the date the person entered the United States.

4) Notwithstanding the provisions of subsections (b)(1) and (2) of this Section, any non-citizen is eligible for medical assistance if the non-citizen otherwise meets the income, asset and categorical requirements of the medical assistance program and is in need of emergency services required after the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

A) placing the non-citizen's health in serious jeopardy;

B) serious impairments to bodily functions; or

C) serious dysfunction of any organ or part (42 USC 1396(b)(v)).

(Source: Amended at 34 Ill. Reg. 889, effective December 30, 2009)

Section 120.311 Residence

a) Only those persons who are legally admitted to the United States can be found to be residents of the State of Illinois.

b) In order to be eligible an individual must be a resident of Illinois, but does not require actual physical presence within the State.

c) An individual is a resident of Illinois if living in Illinois (as defined by Section 2-10 of the Illinois Public Aid Code, Ill. Rev. Stat. 1983, ch. 23, par. 2-10) or if living in an out-of-state institution (as defined at 42 CFR 435.403(b)(1984)) and was placed there by an Illinois Agency unless:

1) the individual maintains a house, apartment or other home in another State; or

2) the individual voluntarily leaves the out-of-state institution in which the individual was placed by an Illinois agency and does not return to Illinois; or

3) the individual is receiving a State Supplementary Payments (as defined at 42 CFR 435.4 (1984), Mandatory State Supplement or Optional State Supplement) from another State as a resident of that State; or

4) the individual was placed in an institution located in Illinois by another State.

d) An out-of-State Title IV-E eligible adoption assistance/foster care child living in Illinois is considered an Illinois resident for medical assistance coverage.

e) An Illinois resident who is temporarily absent from the State retains Illinois residency if the individual intends to return to Illinois when the reason for the absence is accomplished. If an individual remains outside of Illinois for a continous period of more than twelve (12) months, he/she must provide evidence (e.g. a copy of his/her most recent State Income Tax return) documenting that the absence was not due to an intent to change his/her residency.

(Source: Amended at 12 Ill. Reg. 6234, effective March 22, 1988)

Section 120.312 Age

a) There is no age requirement for the Aid to the Aged, Blind or Disabled (Blind) (AABD(B)) and Aid to the Aged, Blind or Disabled (Disabled) (AABD(D)) Medical Assistance – No Grant (MANG) programs

b) An individual must be 65 year of age or older to qualify for Aged, Blind or Disabled (Aged) (AABD(A)) – Medical Assistance – No Grant (MANG).

c) To be designated as or to receive medical assistance as a caretaker relative in an AFDC-MANG case there is no minimum or maximum age requirement.

d) To be included in an AFDC-MANG case as a dependent child, a child must be under age 18 or age 18 and a full time high school senior (or equivalent level) and will finish school before reaching age 19.

e) If an individual receives medical assistance as a caretaker relative in an AFDC-MANG case that individual shall not be considered as a child in the determination of the of the medical assistance standard.

(Source: Amended at 7 Ill. Reg. 8264, effective July 5, 1983)

Section 120.313 Blind

MANG(B)

a) To be eligible for medical assistance as a blind person an individual must be determined blind as currently defined by the Social Security Administration (SSA). (See 20 CFR 416, Subpart I, April 1, 1984).

b) If an individual is receiving Supplemental Security Income (SSI) or primary Social Security (OASDI) benefits, the Department shall accept the Social Security Administration determination of blindness. The Department will make the determination when the client has been denied SSI on the basis of too much income or when the client is applying for medical assistance only and not receiving SSI or OASDI. The Department uses the same criteria for blindness as is used under SSI. (See 20 CFR 416, Subpart I, April 1, 1984).

c) 1) If an individual applying for or receiving medical assistance is determined currently "not blind" by SSA under the SSI or primary OASDI programs, the Department shall accept SSA's determination of blindness and deny or cancel the case, no matter which agency made the original determination of eligibility.

2) If the individual appeals the SSA determination of blindness to SSA, medical assistance shall be continued for recipients through the level of a determination by an Administrative Law Judge (ALJ) subject to the time limits of (c)(3) below. If medical assistance has been cancelled but the client later appeals to SSA, the case shall be reinstated through the ALJ level subject to the time limits of c)3) below.

3) If the client notifies the Department of his appeal to SSA within 10 days of the date of the Department notice, medical assistance will be continued with no break. If the client notifies the Department of his appeal to SSA within 11 through 65 days of the date of the Department notice, medical assistance will be reinstated back to the original date of cancellation. If the client notifies the Department of his appeal to SSA more than 65 days after the date of the Department notice, medical assistance will be provided prospectively only, unless the client actually appealed to SSA within 65 days of the date of the Department notice, in which case medical assistance will be reinstated back to the original date of cancellation.

4) Medical assistance shall not be provided to applicants for medical assistance through the SSA appeals process.

5) If an Administrative Law Judge finds the individual "not blind", the Department shall accept that finding as final. The individual shall not have the right to appeal the determination of blindness to the Department at any time during this process.

d) Redetermination of blindness is a condition of continuing eligibility for individuals who are not applying for or receiving SSI or OASDI benefits.

e) When appropriate, the Department shall pay for a medical examination to determine blindness.

(Source: Amended at 8 Ill. Reg. 6770, effective April 27, 1984)

Section 120.314 Disabled

MANG(D)

a) To be eligible for medical assistance as a disabled person an individual must be determined disabled as currently defined by the Social Security Administration. (See 20 CFR 416, Subpart I, April 1, 1984.)

b) If an individual is receiving Supplemental Security Income (SSI) or primary Social Security (OASDI) benefits, the Department shall accept the Social Security Administration determination of disability. The Department will make the determination when the client has been denied SSI on the basis of too much income or when the client is applying for medical assistance only and not receiving SSI or OASDI. The Department uses the same criteria for disability as is used under SSI. (See 20 CFR 416, Subpart I, April 1, 1984).

c) If a child was terminated from SSI due to the August 22, 1996, change in disability standards (Public Law 104-193), and the child was eligible for both Medicaid and SSI on August 22, 1996, the child is considered disabled unless:

1) the child becomes 18, or

2) the child has not received Medicaid for 12 months, or

3) the child no longer meets the pre-August 22, 1996, definition of disability.

d) Appeals

1) If an individual applying for or receiving medical assistance is determined currently "not disabled" by SSA under the SSI or primary OASDI programs, the Department shall accept SSA's determination of disability and deny or cancel the case, no matter which agency made the original determination of eligibility.

2) If the individual appeals the SSA determination of disability to SSA, medical assistance shall be continued for recipients through the level of a determination by an Administrative Law Judge (ALJ) subject to the time limits of subsection (d)(3) of this Section. If medical assistance has been canceled, but the client later appeals to SSA, the case shall be reinstated through the ALJ level subject to the time limits of subsection (d)(3) of this Section.

3) If the client notifies the Department of his or her appeal to SSA within ten

days after the date of the Department notice, medical assistance will be continued with no break. If the client notifies the Department of his or her appeal to SSA within 11 through 65 days after the date of the Department notice, medical assistance will be reinstated back to the original date of cancellation. If the client notifies the Department of his or her appeal to SSA more than 65 days after the date of the Department notice, medical assistance will be provided prospectively only, unless the client actually appealed to SSA within 65 days after the date of the Department notice, in which case medical assistance will be reinstated back to the original date of cancellation.

4) Medical assistance shall not be provided to applicants for medical assistance through the SSA appeals process.

5) If an Administrative Law Judge finds the individual "not disabled", the Department shall accept that finding as final. The individual shall not have the right to appeal the determination of disability to the Department at any time during this process.

e) Redetermination of disability is a condition of continuing eligibility for individuals who are not applying for or receiving SSI or OASDI benefits.

f) When appropriate, the Department shall pay for a medical examination to determine disability.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

Section 120.315 Relationship

MANG(C)

a) The child(ren) must be living with a blood relative, step-relative or adoptive relative in the relative's home.

b) The required relationship does not exist between a child born out-of-wedlock and the child's father or the father's relatives unless:

1) paternity has been adjudicated;

2) the father has acknowledged paternity in open court or by notarized written statement within the last two years; or

3) the father has contributed to the child's support within the last two years and had previously acknowledged paternity in open court or by notarized written statement.

c) A child conceived or born in wedlock is presumed to be the child of the marriage in the absence of a court finding to the contrary.

d) When the required relationship exists between the child and the relative, the relative is referred to as a specified relative.

Section 120.316 Living Arrangement

All persons included in the assistance unit must be residing in the same household. To be included in the assistance unit as a child, the child must live with a specified relative in that relative's home. The relative must exercise primary responsibility for care and supervision of the child, even though either the child or the relative is temporarily absent from the customary family setting.

Section 120.317 Supplemental Payments

a) MANG(AABD)

State Supplemental Payments (SSP) shall be available to supplement the income of those individuals whose age, disability, or blindness would (apart from consideration of income) satisfy the eligibility factors of the Federal SSI program. Eligibility shall not exist if SSI payments would be higher in the absence of the SSP payments, or if the individual refuses or neglects to make application for assistance from SSI when so directed by the Department. Receipt of SSI is not a requirement of eligibility for SSP. Having made application for SSI benefits is an eligibility requirement for receipt of SSP; however denial of the SSI application does not preclude ineligibility for SSP unless SSI was denied due to a finding of "not aged", "not blind" or "not disabled". An individual determined by SSA as not aged, blind or disabled, is not eligible for SSP.

b) MANG(C)

An individual who is eligible for either MANG(C) or SSP shall have a choice between the two programs. In no instance may that individual receive both MANG(C) and SSP.

Section 120.318 Institutional Status

a) Individuals residing in public institutions (see 42 CFR 435.1009) are ineligible for medical assistance, except as provided in subsections (b) and (c) of this Section.

b) For individuals confined or detained in any local or State penal or correctional institution who are otherwise eligible for, and enrolled in, medical assistance authorized under Article V of the Illinois Public Aid Code [305 ILCS 5], benefits shall be limited to those services reimbursed by the Department as described in 89 Ill. Adm. Code 140.10. The limitation shall be lifted upon timely notice to the Department that the individual has been released. The notice must confirm that the individual is residing in Illinois and shall include an address through which the individual may be contacted. This change shall take effect upon adoption of this amended rule for persons who are eligible for medical assistance because they have attained the age of 65, are blind or have a disability. For all other individuals, this change shall take effect no later than January 1, 2012.

c) Nothing in subsection (b) shall affect the eligibility of pregnant women whose medical care during pregnancy is eligible for federal reimbursement of the cost of care provided to an unborn child.

d) Individuals who are confined or detained by a federal law enforcement agency are ineligible for medical assistance.

e) A resident of a private institution who has a contract with the institution providing total needs throughout life is ineligible, as no needs remain to be met.

f) Residents of private institutions (other than those who have purchased life care contracts) are ineligible for public assistance when they have purchased care and maintenance to provide for all their needs in the institution and the amount paid has not been wholly consumed for care.

g) Individuals, living in a public or a private facility that has official policies and administrative procedures that are not in conformance or are in conflict with the Illinois Public Aid Code provision or Department rules governing eligibility for medical assistance, are ineligible for medical assistance.

(Source: Amended at 35 Ill. Reg. 379, effective December 27, 2010)

Section 120.319 Assignment of Rights to Medical Support and Collection of Payment

a) Assignment of Rights to Medical Support

1) By accepting medical assistance under the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 5-2), a custodial relative, spouse, or a parent shall be deemed to have made assignment to the Department of any and all rights, title, and interest in any medical support obligations up to the amount of medical assistance provided (Ill. Rev. Stat. 1989, ch. 23, par. 10-1). The rights to medical support assigned to the Department shall constitute an obligation owed to the State by the person who is responsible for providing the support and is collectable under all available processes.

2) This right includes the rights of any individual or any other person who is eligible for medical assistance and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purposes of medical care by a court or administrative order) and to a payment for medical care from any third party.

b) To enforce and collect these payments, the State Medicaid agency may enter into cooperative agreements with the State IV-D agency (i.e., the Division of Child Support Enforcement within the Department of Public Aid) and other appropriate agencies, courts and law enforcement officials, to assist in making collections.

c) Amounts of medical support or third party payments collected under this assignment shall be retained by the Department as necessary, to reimburse the Department for medical assistance payments made on behalf of an individual for whom an assignment was executed. Any remaining amount of such collection shall be paid to the individual who executed the assignment.

d) When an individual is no longer receiving medical assistance the assignment of medical support rights terminates except for any medical support owed to the Department for the period of time medical assistance was issued.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.320 Cooperation in Establishing Paternity and Obtaining Medical Support

a) In accordance with 89 Ill. Adm. Code 160.30, as a condition of eligibility for medical assistance a caretaker relative or spouse included in the assistance unit, who assigned to the Department his/her rights to medical support, shall cooperate with the Department in:

1) establishing the paternity of a child born out-of-wedlock, for whom the individual can legally assign rights; and

2) obtaining medical support and payments on his or her own behalf and on behalf of those persons for whom the client has assigned rights.

b) Cooperating with the Department in establishing paternity and obtaining medical support payments includes:

1) appearing at such places as the Department's offices or the offices of the Department's legal representative, as necessary, to provide information or evidence, known to, possess by or reasonably obtainable by the client (e.g. identity/location of the legally responsible relative, or identity/location of a third party who has information regarding the legally responsible relative), or attest to the lack of information under penalty of perjury;

2) appearing and testifying as a witness at judicial proceedings;

3) paying to the Department any medical support payments or third party payments for medical care; and

4) taking any other reasonable steps to assist in establishing paternity and securing medical support and payments (e.g. signing legal documents (complaints), submitting to blood tests).

c) 1) If the caretaker and his/her spouse are in the home and included in the assistance unit, both must comply with the cooperation requirements unless the Department determines the individual is exempt from cooperation for good cause. A caretaker relative or spouse who fails or refuses without good cause, to cooperate in establishing paternity or securing medical support, shall be excluded from the medical assistance unit.

2) The remaining eligible assistance unit members, shall be authorized medical assistance through a representative payee, until such time as the person meets the cooperation requirement. A representative payee is a

specified relative in all cases other than those listed in 89 Ill. Adm. Code 117.10.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.321 Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support

a) The Department shall inform the caretaker relative of his/her right to claim an exemption from cooperation, based on a claim of good cause.

b) With respect to claiming good cause for exemption as not in the best interests of a child for whom an assignment was executed, the Department's Good Cause policy at 89 Ill. Adm. Code 160.35, shall apply.

c) With respect to claiming good cause for exemption as not in the best interests of the caretaker relative or any individual other than the child for whom an assignment was executed, the Department's Good Cause policy at 89 Ill. Adm. Code 160.35, shall apply excluding those parts applicable only to children.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.322 Proof of Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support

a) With respect to the caretaker relative proving/ documenting a claim of good cause as not in the best interest of the child, the Department's Proof of Good Cause policy at 89 Ill. Adm. Code 160.40, shall apply.

b) With respect to the caretaker relative proving/ documenting a claim of good cause as not in the best interest of a person other than a child, the Department's Proof of Good Cause policy at 89 Ill. Adm. Code 160.40, shall apply, excluding those parts applicable only to children.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.323 Suspension of Paternity Establishment and Obtaining Medical Support Upon Finding Good Cause

a) Upon a caretaker relative's claim of good cause, the Department will suspend all activities to establish paternity or secure medical support payments until a final determination is made on the good cause claim.

b) The Department shall not undertake to establish paternity or secure medical support payments when the Department determines that good cause for exemption exists.

c) This suspension shall be in accordance with 89 Ill. Adm. Code 160.45, Suspension of Child Support Enforcement Upon Finding of Good Cause.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.324 Health Insurance Premium Payment (HIPP) Program

a) This program provides health insurance coverage for recipients who have health insurance available and have high cost medical expenses. Authorization for the Health Insurance Premium Payment Program (HIPP) was established by Section 4402 of OBRA 1990 which added Section 1906 to the Social Security Act.

b) Program Provisions

1) The HIPP Program shall provide for the mandatory enrollment of eligible persons in available cost effective group or individual health plans as a condition of medical assistance eligibility. A group health plan is "any plan of, or contributed to by, an employer (including a self insured plan) to provide health care to the employer's employees, former employees, or families of such employees or former employees." An individual health plan is a contract for health insurance coverage between an individual and an insurance company.

2) The Department shall pay health insurance premiums for eligible medical assistance recipients whenever it is likely to be cost effective.

c) Program Standards

1) The HIPP program shall be limited to persons otherwise eligible for medical assistance (excluding spenddown and long term care clients) who have high cost medical conditions such as, but not limited to:

A) Severe arthritis;

B) Cancer;

C) Heart ailment or defect;

D) Liver disease or dysfunction;

E) Kidney disease or dysfunction;

F) Brain disease or disorder;

G) Neurological disease or disorder;

H) Diabetes;

I) Acquired Immune Deficiency Syndrome (AIDS);

J) Organ transplant; and

K) Any other medical condition requiring high cost ongoing medical treatment.

2) To be eligible for medical assistance, a client with a high cost medical condition who can enroll in a group or individual health plan must supply information about the health plan. The client must enroll (or re-enroll) if:

A) the client can enroll on his or her own behalf, and

B) the plan covers the client's high cost medical condition, and

C) the plan is determined by the Department to be cost effective.

3) A client that fails to enroll in a cost effective health plan, is ineligible for medical assistance until the next enrollment period and proof of enrollment is provided.

4) Determination of the cost effectiveness shall be made by the Department on a case by case basis using prior medical history.

5) Cost effective means the average cost of medical services for the period of time covered by the health insurance premium is greater than twice the premium cost for the period.

6) The Department will notify the client that enrollment is necessary because the plan is cost effective. The client will have the right to appeal this determination according to the rules in 89 Ill. Adm. Code 102.80.

7) When the policy covers other family members only the client's share of the premium will be paid by HIPP unless retention of the policy is contingent upon paying premiums for other medical assistance eligible recipients.

8) Payment of premiums for a non-eligible family member may be made if necessary to enroll the HIPP participant. A non-eligible family member may reside in another household. Deductibles and co-insurance shall not be paid for the non-eligible family members. Premiums shall not be paid if the non-eligible family member is required to enroll dependent(s) through a divorce order or order for medical support.

9) Health insurance premiums may be paid directly to employers, unions or insurance companies.

10) Clients paying their own premiums shall be reimbursed only if premium payments are made through payroll deduction or the client has already paid the premium. Reimbursement of premium shall only be made after the client accumulates a minimum of $50.00 in payments and submits proof of payment.

11) HIPP shall pay deductibles and co-payments based on the Department's medical payment standards.

12) Medical assistance payments shall be made for items and services covered under the Medical Assistance Program which are not covered by the health plan.

13) Premium payments may be made prior to case approval or certification only when it appears likely that the case will be approved or certified and timely payment or enrollment is crucial to the retention of coverage.

14) Assignment of medical support rights provisions shall apply to any health insurance premium for which the Department pays or reimburses the client. If the client receives a return of premium, for any reason, from the insurance carrier, the returned premium must immediately be turned over to the Department, or be subject to recovery.

15) Insurance payments for medical services shall be assigned to the medical provider at the time the services are requested. In the event a client receives an insurance payment for medical services which were also paid by the Department, the client must immediately turn the payment over to the Department, or be subject to recovery.

(Source: Section repealed, new Section adopted at 18 Ill. Reg. 5934, effective April 1, 1994)

Section 120.325 Health Insurance Premium Payment (HIPP) Pilot Program

a) The pilot program will begin on January 1, 1994 and will operate for a minimum of three (3) months.

b) The pilot program will be conducted in Auburn Park, Peoria and Winnebago Local Offices.

c) The rules for the pilot program are in Section 120.324, Health Insurance Premium Payment Program.

(Source: Section repealed, new Section adopted at 18 Ill. Reg. 5934, effective April 1, 1994)

Section 120.326 Foster Care Program

a) A child is eligible for MANG(C) when:

1) The child has been removed from the home of a specified relative as a result of court action, is a child for whom DCFS is legally responsible, and has been placed in foster care (foster care home, or private non-profit, group home institution) which is licensed or approved by the Department of Children and Family Services; and

2) The child was eligible for and receiving MANG(C) in or for the month in which court action was initiated leading to placement; or

3) The child met the citizenship, age, residence, need, and lack of parental support or care criteria for MANG(C) at the time of initiation of court action and lived with a specified relative at any time within the six (6) months prior to the initiation of court action leading to placement; and

4) The child continues to meet AFDC eligibility requirements of age, need, lack of parental support or care, and registration/participation requirements.

b) An application for AFDC-F must be signed by an authorized representative of the Department of Children and Family Services.

c) Assistance under the AFDC-F program is effective from the latter of the date:

1) that a completed application is received by the Department; or

2) the child is actually placed in foster care.

d) A foster parent who is a specified relative of an eligible foster child placed in the foster parent's care may receive assistance for the child under either the AFDC-R/AFDC-U or the AFDC-F program.

(Source: Added at 18 Ill. Reg. 5934, effective April 1, 1994)

Section 120.327 Social Security Numbers

a) To be eligible for AABD or AFDC MANG, each individual must furnish the Department his/her Social Security Number(s) (SSN). If more than one SSN has been assigned to any individual(s), all numbers are to be furnished.

b) If a SSN cannot be furnished, either because it has not been issued or is not known, application shall be made for a SSN.

c) Medical assistance will not be denied, delayed or discontinued pending the issuance or validation of a SSN if the individual, or someone acting responsibly for the individual, applies for the SSN.

d) Individuals for whom a SSN is not furnished and for whom application for a SSN is not made are ineligible for medical assistance under the AABD or AFDC MANG program.

(Source: Added at 18 Ill. Reg. 5934, effective April 1, 1994)

Section 120.329 Compliance with Non-Economic Eligibility Requirements of Article IV (Suspended; Repealed)

(Source: Added by peremptory rulemaking at 32 Ill. Reg. 18889, effective November 18, 2008; peremptory rule suspended at 32 Ill. Reg. 18906, effective November 19, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 33 Ill. Reg. 6551, effective April 28, 2009; peremptory rule repealed by emergency rulemaking at 33 Ill. Reg. 6712, effective April 28, 2009, for a maximum of 150 days; peremptory rule repealed at 33 Ill. Reg. 12703, effective September 7, 2009)

Section 120.330 Unearned Income

a) All currently available, unearned income which is not specified as exempt shall be considered in the determination of eligibility.

b) Unearned income is all income other than that received in the form of salary for services performed as an employee or profits from self-employment. Unearned income includes any amount of interest earned from assets disregarded by Section 120.382(a)(3) and (a)(4).

c) When the amount of unearned income to be considered is determined, the cents are dropped from each payment amount.

d) For payments received weekly, the weekly amount is multiplied by 4.33 to determine the countable monthly income.

e) For payments received bi-weekly, the bi-weekly amount is multiplied by 2.16 to determine the countable monthly income.

(Source: Amended at 21 Ill. Reg. 13638, effective October 1, 1997)

Section 120.332 Budgeting Unearned Income

Monthly unearned income of a client is budgeted on the basis of income anticipated to be received during the budgeting period. Computation is to be based on information provided by the client and verification of that information. All income is to be converted into monthly amounts. Budgeting occurs upon initial determination, upon redetermination and when the client reports a change in the source or amount of income received.

(Source: Amended at 3 Ill. Reg. 3, p. 399, effective August 18, l979)

Section 120.335 Exempt Unearned Income

a) MANG (AABD)

1) For a MANG client (excluding long term care), the first $25.00 of a client's earned or unearned income other than SSI income, or contributions from a spouse or other individual, is exempt from consideration in determining eligibility. A client is eligible for only one $25.00 exemption regardless of the types of sources of earned or unearned income.

2) If an individual in a long term care facility is paying the premium for SMIB coverage, the cost of the premium shall be disregarded.

3) SSI income received by a long term care case who is in Section 1619 of the Social Security Act (42 USC 1382h) status (see 89 Ill. Adm. Code 140.8) in the month before admission to the facility is exempt for the first full two months of stay in the facility.

b) The following unearned income shall be exempt from consideration in determining MANG eligibility:

1) The value of the coupon allotment under the Food Stamp Act of 1977 (7 USC 2017(b));

2) The value of the U.S. Department of Agriculture donated foods (surplus commodities);

3) Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (42 USC 4636);

4) Any per capita judgment funds paid under P.L. 92-254 to members of the Blackfeet Tribe of the Blackfeet Indian Reservation, Montana and the Gros Ventre Tribe of the Fort Belknap Reservation, Montana (25 USC 1264);

5) Any benefits received under Title III, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended (42 USC 3030e);

6) Any compensation provided to individual volunteers under the Retired Senior Volunteer Program and the Foster Grandparent Program and Older Americans Community Service Programs established under Title II of the Domestic Volunteer Service Act, as amended;

7) Income in an amount not greater than $650 received by a beneficiary of life insurance which is expended on the funeral and burial of an insured recipient;

8) Income received under the provisions of Section 4(c) of the Illinois Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act [320 ILCS 25]. This includes both the benefits commonly known as the circuit breaker and "additional grants";

9) Payments to volunteers under the 1973 Domestic Volunteer Service Act. (48 USC 5044(q)) These include:

A) Vista Volunteers;

B) Volunteers serving as senior health aids, senior companions, or foster grandparents;

C) Persons serving in the Service Corps of Retired Executives (SCORE) or the Active Corps of Executives (ACE); and

10) Unearned income such as need based payments, cash assistance, compensation in lieu of wages and allowances received through the Jobs Training Partnership Act.

c) The following additional unearned income shall be exempt:

1) Social Security death benefit expended on a funeral and/or burial.

2) The value of home produce which is used for personal consumption.

3) The value of supplemental food assistance received under the Child Nutrition Act of 1966, as amended, (42 USC 1780(b)) and the special food service program for children under the National School Lunch Act, as amended (42 USC 1760).

4) Any payments distributed per capita or held in trust for members of any Indian Tribe under P.L. 92-254, P.L. 93-134 or P.L. 94-450 (25 USC 1407).

5) Tax exempt portions of payments made pursuant to the Alaska Native Claims Settlement Act (43 USC 1626).

6) Experimental Housing Allowance Program payments made under Annual

Contributions Contracts entered into prior to January 1, 1975 under Section 23 of the U.S. Housing Act of 1937, as amended (42 USC 1437(f)).

7) The first $50 of the total child support payments received each month on behalf of the assistance unit members. The amount of up to $50 exempted is based on the total child support received in a month, regardless of the number of parents who contribute. Both court ordered and voluntary payments are considered when exempting the first $50 of child support payments.

8) A Title IV-E adoption assistance payment or foster care payments received from a state welfare agency of another state.

9) Income from a trust fund established under the Self Sufficiency Trust Fund Program [20 ILCS 1705/21.1].

10) Payments made to veterans who receive an annual disability payment or to the survivors of deceased veterans who receive a one-time lump sum payment from the Agent Orange Settlement Fund or any other fund referencing Agent Orange product liability under P.L. 101-201.

11) Payments made by the Illinois Department of Mental Health and Developmental Disabilities under the Family Assistance Program for Mentally Disabled Children [405 ILCS 80/3-1].

12) Payments received from a fund established by a State to aid victims of crime.

13) Federal Additional Compensation payments made by the Illinois Department of Employment Security under the American Recovery and Reinvestment Act of 2009 (Div. B, Title II, Sec. 2001 of P.L. 111-5).

14) Economic Recovery payments made by the Social Security Administration under the American Recovery and Reinvestment Act of 2009 (Div. B, Title II, Sec. 2201 of P.L. 111-5).

15) Tax Credit for Certain Government Retirees under the American Recovery and Reinvestment Act of 2009 (Div. B, Title II, Sec. 2202 of P.L. 111-5).

16) Payments to veterans who served in World War II in the Philippines and to spouses of those veterans under Section 1002 of the American Recovery and Reinvestment Act of 2009 (Div. A, Title X, Sec. 1002 of

P.L. 111-5).

17) Payments or reimbursements for Premium Assistance for COBRA Continuous Coverage under the American Recovery and Reinvestment Act of 2009 (Div. B, Title III, Sec. 3001 of P.L. 111-5).

Source: Amended at 33 Ill. Reg. 12703, effective September 7, 2009)

Section 120.336 Education Benefits

The following education benefits shall be exempt:

a) Veterans Educational Assistance
Income from educational benefits paid to a veteran or to a dependent of a veteran.

b) Social Security Administration Benefits
Income received as an SSA benefit paid to or for an individual and conditioned upon the individual's regular attendance in a school, college or university, or a course of vocational or technical learning.

c) All other education grants and loans.

(Source: Amended at 28 Ill. Reg. 4701, effective March 3, 2004)

Section 120.338 Incentive Allowance

The following incentive allowances shall be exempt:

a) National Training Services Grant
Incentive payments which the Division of Vocational Rehabilitation authorizes to be paid to disabled persons receiving categorical assistance and enrolled in the National Training Service Project.

b) Work Incentive Demonstration Program (WDP) Incentive Payments.

(Source: Amended at 8 Ill. Reg. 13328, effective July 16, l984)

Section 120.340 Unearned Income In-Kind

a) Unearned Income in-kind is payment made by a non-member of the assistance unit in behalf of or in the name of a member of the assistance unit.

b) Unearned income in-kind shall be exempt.

c) When the assistance unit shares a dwelling unit with another family or individual(s), the exchange of cash for purposes of satisfying payment of shelter related obligations shall not constitute an income in-kind payment and shall not be considered available to meet the needs of the person who receives and disburses the shelter-related payment.

(Source: Amended at 3 Ill. Reg. 33, p. 399, effective August l8, l979)

Section 120.342 Child Support and Spousal Maintenance Payments

a) Court ordered child support and/or spousal maintenance (alimony) payments shall be deducted from nonexempt income in determining the countable income of the person making the payment.

b) Voluntary child support and/or spousal maintenance payments made for persons for whom the payer is legally responsible according to 89 Ill. Adm,. Code 103.10 shall be deducted from nonexempt income in determining the countable income of the responsible relative.

c) These deductions cannot exceed the total amount of countable income.

(Source: Amended at 26 Ill. Reg. 9846, effective June 26, 2002)

Section 120.345 Earmarked Income

a) Earmarked income is income restricted for the use of a specified individual by court order, or by legal stipulation of a contributor.

b) MANG(AABD)
Earmarked income shall be budgeted against the needs of the specified individual only.

c) MANG(C)
Earmarked income shall be considered available to meet the family's needs. The caretaker relative may request that any individual receiving earmarked income sufficient to meet that individual's need be deleted from the assistance unit. In that instance, the earmarked income shall be considered available to meet the needs of the deleted individual and the needs of person(s) for whom the individual is legally responsible.

(Source: Amended at 3 Ill. Reg. 33, p. 399, effective August 8, l979)

Section 120.346 Medicaid Qualifying Trusts

a) This Section applies to trusts established prior to August 11, 1993.

b) The maximum amount of payment permitted under the terms of a Medicaid qualifying trust (described in subsection (c) below) shall be considered in determining eligibility for medical assistance, whether or not the maximum amount was distributed to the individual. The maximum amount is considered in determining eligibility for medical assistance, whether or not the trust is irrevocable or established for reasons other than to qualify for Medicaid.

c) A Medicaid qualifying trust is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

(Source: Amended at 19 Ill. Reg. 2905, effective February 27, 1995)

Section 120.347 Treatment of Trusts and Annuities

a) This Section applies to trusts established on or after August 11, 1993.

b) A trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed or administered by the trustee or trustees for the benefit of the grantor or designated beneficiaries. A trust also includes any legal instrument or device that is similar to a trust, including an annuity.

c) A person shall be considered to have established a trust if resources of the person were used to form all or part of the principal of the trust and the trust is established (other than by will) by any of the following:

1) the person;

2) the person's spouse; or

3) any other person, including a court or administrative body, with legal authority to act on behalf of or at the direction of the person or the person's spouse.

d) This Section does not apply to the following trusts:

1) an irrevocable trust containing the resources of a person who is determined disabled (as provided in Section 120.314) and under age 65 that is established by a parent, grandparent, legal guardian or court for the sole benefit (as defined in Section 120.388(m)(2)) of the person, if language contained in the trust stipulates that any amount remaining in the trust (up to the amount expended by the Department on medical assistance) shall be paid to the Department upon the death of the person. This exclusion continues after the person reaches age 65 as long as the person continues to be disabled but any additions made by the person to the trust after age 65 will be treated as a transfer of assets under Sections 120.387 and 120.388. If the trust contains proceeds from a personal injury settlement, any Department charge (as described at 89 Ill. Adm. Code 102.260) must be satisfied in order for the trust to be excluded under this subsection; or

2) an irrevocable trust containing the resources of a person who is determined disabled (as provided in Section 120.314) that is established and managed by a non-profit association that pools funds but maintains a separate account for each beneficiary that is established by the disabled

person, a parent, grandparent, legal guardian or court for the sole benefit of the disabled person, if language contained in the trust stipulates that any amount remaining in the trust (up to the amount expended by the Department on medical assistance) that is not retained by the trust for reasonable administrative costs related to wrapping up the affairs of the subaccount shall be paid to the Department upon the death of the person. This exclusion continues after the person reaches age 65 as long as the person continues to meet the definition of disabled (to the extent permitted under federal law). Any funding of a subaccount in a pooled trust by a person over age 64 will be treated as a transfer for fair market value under Section 120.388 so long as the person meets the definition of disabled. If the trust contains proceeds from a personal injury settlement, any Department charge (as described at 89 Ill. Adm. Code 102.260) must be satisfied in order for the trust to be excluded under this subsection (d).

e) Subsections (f) and (g) of this Section apply to the portion of the trust attributable to the person and without regard to:

1) the purpose for establishment of the trust;

2) whether the trustee has or exercises any discretion under the trust; or

3) whether there are any restrictions on distributions or use of distributions from the trust.

f) For revocable trusts, the Department shall:

1) treat the principal as an available resource;

2) treat as income payments from the trust that are made to or for the benefit of the person; and

3) treat any other payments from the trust as transfers of assets by the person (subject to the provisions of, and depending on the date of the payment, Section 120.387 or 120.388).

g) For irrevocable trusts, the Department shall:

1) treat as an available resource the amount of the trust from which payment to or for the benefit of the person could be made;

2) treat as income payments from the trust that are made to or for the benefit of the person;

3) treat any other payments from the trust as transfers of assets by the person (subject to the provisions of Section 120.387 or 120.388, as applicable); and

4) treat as a transfer of assets by the person the amount of the trust from which no payment could be made to the person under any circumstances (subject to the provisions of Section 120.387 or 120.388, as applicable). The date of the transfer is the date the trust was established or, if later, the date that payment to the person was foreclosed. The amount of the trust is determined by including any payments made from the trust after the date that payment to the person was foreclosed.

h) Trust Income. For married couples, income from trusts shall be attributed to each spouse as provided in the trust, unless:

1) payment of income is made solely to one spouse, in which case the income shall be attributed to that spouse;

2) payment of income is made to both spouses, in which case one-half of the income shall be attributed to each spouse; or

3) payment of income is made to either spouse, or both, and to another person or persons, in which case the income shall be attributed to each spouse in proportion to the spouse's interest, or, if payment is made to both spouses and no such interest is specified, one-half of the joint interest shall be attributed to each spouse.

i) Annuities are treated similar to trusts.

1) Revocable and assignable annuities are considered available resources.

2) Any portion of an annuity from which payment to or for the benefit of the person or the person's spouse could be made is an available resource. An annuity that may be surrendered to its issuing entity for a refund or payment of a specified amount or provides a lump-sum settlement option is an available resource valued at the amount of any such refund, surrender or settlement.

3) Income received from an annuity by an institutionalized person is considered non-exempt income. Income received by the community spouse of an institutionalized person is treated as available to the community spouse for the purpose of determining the community spouse income allowance under Section 120.379(e).

4) An annuity that fails to name the State of Illinois as a remainder beneficiary as required under Section 120.385(b) shall result in denial or termination of eligibility for long term care services.

j) The principal of a trust fund established under the Self Sufficiency Trust Fund Program (see 20 ILCS 1705/21.1) is an exempt resource.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.350 Lump Sum Payments and Income Tax Refunds

a) Lump sum payments shall be considered available for the established six month period in which it is received.

b) For a MANG client who resides in the community, SSI lump sum payments are exempt income. SSI lump sum payments that are kept separately and are not combined with other monies remain exempt.

c) For a MANG client who resides in a group care facility, DMHDD facility or other medical facility, SSI lump sum payments are considered non-exempt income. The lump sum payment is considered available to meet the needs of the individual for the established six month period in which it is received.

(Source: Amended at 7 Ill. Reg. 394, effective January 1, 1983)

Section 120.355 Protected Income

a) MANG(AABD)

1) Supplemental Security Income (SSI) is protected income and not considered available to meet the needs of any other person.

2) For a MANG client who resides in the community, SSI lump sum payments are exempt income. SSI lump sum payments that are kept separately and are not combined with other monies remain exempt.

3) For a MANG client who resides in a group care facility, DMHDD facility or other medical facility, SSI lump sum payments are considered non-exempt income. The lump sum payment is considered available to meet the needs of the individual for the established six month period in which it is received.

b) MANG(C)

All income and assets of a Supplemental Security Income (SSI) beneficiary shall be protected and shall not be considered available to meet the needs of any MANG(C) applicant or recipient.

(Source: Amended at 5 Ill. Reg. 8041, effective July 27, 1981)

Section 120.360 Earned Income

a) All currently available income which is not specified as exempt is considered in the determination of eligibility.

b) Earned income is remuneration acquired through the receipt of salaries or wages for services performed as an employee or profits from an activity in which the individual is self-employed.

c) AFDC (MANG)

1) Earned income received through the Job Training Partnership Act by dependent children who are full-time students or who are part-time students and not employed full-time (i.e., working 100 hours or more per month) is exempt (see 89 Ill. Adm. Code 112.140 for a definition of "full-time student" and "part-time student"). Participants in Job Corps are considered students.

2) Earned income received through the Job Training Partnership Act by dependent children who are not students as described in subsection (c)(1) of this Section is exempt for six months each year.

d) AABD (MANG)
Earned income received through the Job Training Partnership Act must be budgeted against the AABD MANG standard.

e) When the amount of earned income to consider is determined, the cents are dropped from each payment amount.

(Source: Amended at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.361 Budgeting Earned Income

a) Budgeting is the method by which nonexempt income is compared to the applicable MANG Standard (as contained in Sections 120.20, 120.30 and 120.31).

b) For persons who are paid weekly, the average gross weekly payment is multiplied by 4.33 to determine the countable gross monthly income.

c) For persons who are paid bi-weekly, the average gross bi-weekly payment is multiplied by 2.16 to determine the countable gross monthly income.

(Source: Amended at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.362 Exempt Earned Income

a) MANG (AABD) (Excluding Long Term Group Care)
The first $25.00 of a client's earned or unearned income, other than SSI or contributions from a spouse or other individual residing outside the home, is exempt from consideration in the determination of eligibility. A client is eligible for only one $25.00 exemption regardless of the type or source of income.

b) Certain additional amounts of earned income shall be exempt:

1) For MANG (AABD(A)(D)), the first $20.00 of gross earned income and one-half of the next $60.00 are exempt.

2) For MANG (AABD(B))

A) The first $85.00 of the gross earned income and one-half of the amount in excess of $85.00 are exempt.

B) Amounts of income as may be necessary for fulfillment of a client's plan for achieving self-support for a period not to exceed 12 months are exempt.

c) MANG(C)
Earned income shall be exempt if it is the earned income of an individual receiving assistance as a dependent child who is:

1) A full-time student in a school (including vocational and technical) college or university approved by the Illinois Office of Education. Full time is defined as follows:

A) High School – 25 clock hours per week or enrollment in a secondary education program of training which the school defines as full time attendance;

B) Vocational or Technical School – 30 clock hours per week when the program involves shop practice; 25 hours per week when the program does not involve shop practice; or

C) College or University – 12 semester or quarter hours.

2) A part-time student who is not employed 100 hours per month or more.

(Source: Amended at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.363 Earned Income Disregard – MANG(C)

The first $90.00 of earned income is disregarded from the monthly earned income of each employed person.

(Source: Added at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.364 Earned Income Exemption

a) For MANG(C), the first $30.00 of the combined net earned income of each employed person excluding the earned income of a dependent child (see Sections 120.360 and 120.362) plus one-third of the remainder shall be exempt from consideration. The net income is gross income after the deduction of appropriate business expenses and/or employment expense.

b) After the amount of the earned income exemption is determined, the cents are dropped before the earned income exemption is deducted from the gross unearned income minus the income disregard.

(Source: Amended at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.366 Exclusion From Earned Income Exemption

For MANG(C and CU) the earned income exemption applies:

a) l) If the individual has not already received the earned income exemption as an AFDC grant recipient for four (4) consecutive months; or

2) If an individual received the exemption as an AFDC grant recipient for four (4) consecutive months, he/she has not received AFDC grant assistance for 12 consecutive months since the last month of that four months, then the individual must meet one of the following conditions in order to receive the earned income exemption:

A) the individual's gross income minus the income disregards and self employment business expenses, plus all other nonexempt income, is less than the AFDC Standard of Need, or

B) the individual was an AFDC grant recipient in any one of the four months before the month for which the determination is made.

b) Unless any individual included in the assistance unit other than a dependent child:

1) Terminated employment or reduced earned income without good cause within the period of 30 days preceding such month, or

2) Refused without good cause, within the period of 30 days preceding such month, to accept employment in which the individual was able to engage and which has been determined to be a suitable, available offer of employment, or

3) Fails without good cause to report income in a timely manner.

(Source: Amended at 9 Ill. Reg. 7153, effective May 6, l985)

Section 120.370 Recognized Employment Expenses

a) MANG(AABD)
The following recognized expenses of employment shall be exempt from consideration for MANG(AABD):

1) Withholding taxes (Federal and State);

2) Social Security tax;

3) Transportation at most reasonable rate. If the individual's own car is the most economical means of transportation, l9 cents per mile shall be allowed as transportation expense;

4) Lunch supplementation:

A) If carried from home, 15 cents per working day to a maximum of $3.00 per month;

B) If purchased at work, 45 cents per working day to a maximum of $9.00 per month;

5) Special tools and uniforms required by employment;

*6) Union dues;

*7) Group life insurance premiums;

*8) Group health insurance premiums;

*9) Retirement plan withholding; and

10) The reasonable cost of items and services which are needed and used to enable a disabled person to work.

*Agency Note: Only if mandatory as a condition of employment

b) MANG(C)

1) For employment expenses, $90.00 shall be deducted from the gross earned income of each employed individual.

2) For earnings from self-employment and rental property, an amount equal

to the expenses directly attributable to producing goods or services or an amount equal to the expenses of rental shall be deducted from income.

3) The employment expense allowance is not available to an individual for any month in the following situations:

A) The individual terminated employment or reduced earned income without good cause within the period of 30 days preceding such month;

B) The individual refused without good cause, within the period of 30 days preceding such month, to accept employment in which the individual was able to engage and which has been determined to be a suitable, available offer of employment;

C) The individual fails without good cause to report income in a timely manner; or

D) The individual voluntarily requests AFDC assistance to be terminated to avoid receiving the 30 + l/3 exemption for four consecutive months. (See Section 120.362 through 120.365).

4) Child Care

A) Expenses of child care shall be deducted from income up to a maximum of $200.00 per child for each child under the age of two (2) and $175.00 for each child age two (2) and over.

B) The child care deduction is not allowed when the child care provider is a responsible relative (see 89 Ill. Adm. Code 103.10(b)) of the child receiving care.

(Source: Amended at 15 Ill. Reg. 11973, effective August 12, 1991)

Section 120.371 Income From Work/Study/Training Programs

a) Income from college work-study is considered exempt income.

b) AFDC (MANG)

1) Earned income received through the Job Training Partnership Act by dependent children who are full-time students or who are part-time students and not employed full-time (i.e. working 100 hours or more per month) is exempt (see 89 Ill. Adm. Code 112.140 for a definition of "part-time student" and "full-time student"). Participants in Job Corps are considered students.

2) Earned income received through the Job Training Partnership Act by dependent children who are not students as described in (1) above is exempt for six months each year.

c) AABD (MANG)

1) Earned income received through the Job Training Partnership Act must be budgeted against the AABD MANG standard.

2) Unearned income such as need based payment, cash assistance, compensation in lieu of wages and allowances received through the Job Training Partnership Act is exempt.

(Source: Amended at 8 Ill. Reg. 13328, effective July 16, l984)

Section 120.372 Earned Income From Self-Employment

a) Income realized from self-employment is considered earned income.

b) Accurate and complete records shall be kept on all monies received and spent through self-employment. If the individual fails or refuses to maintain complete business records, the assistance unit is ineligible.

c) Business expenses must be verified. The individual has full responsibility for proof of any business expense. No deduction is allowed for depreciation, obsolescence and/or similar losses in the operation of the business. Gross income from the business is turned back into the business only to replace stock actually sold.

d) The net income is the gross remaining after the replacement of stock and business expenses have been considered, and the appropriate employment expenses and child care expenses, as specified in Section 113, have been deducted. The earned income exemption, if applicable, is computed on the net income.

(Source: Amended at 21 Ill. Reg. 7423, effective May 31, 1997)

Section 120.373 Earned Income From Roomer and Boarder

a) MANG(AABD)

1) Money paid by roomers and/or boarders to a member of an assistance unit who represents himself as being self-employed in the business of renting rooms shall be considered earned income.

2) The following items shall be allowed as deductions for a roomer and boarder.

A) Replacement of towels and bed linen – $l.50

B) Laundry – 554 for additional supplies when the recipient launders the linen; or the roomer's per capita cost when laundry is done commercially

C) Food – if the roomer and boarder receives public assistance, the allowance is the appropriate MANG(AABD) financial standard. If the roomer and boarder does not receive public assistance, the allowance is the appropriate MANG(AABD) standard plus 25% of the allowance

D) Earned income exemptions as applicable.

3) The applicable earned income exemption shall be the only deduction allowed for a roomer who is not also a boarder.

b) MANG(C)
Money paid by roomers and/or boarders to a member of an assistance unit who holds himself out as being self-employed in the business of renting rooms shall be considered earned income.

(Source: Peremptory amendment at 5 Ill. Reg. 10095, effective October 1, 1981)

Section 120.374 Earned Income from Temporary Employment with the Census Bureau

Earned income from temporary employment with the U.S. Census Bureau related to decennial census activities is exempt.

(Source: Added at 33 Ill. Reg. 17070, effective December 2, 2009)

Section 120.375 Earned Income In-Kind

a) Earned income in-kind is remuneration received in a form other than cash for services performed. Such remuneration shall include, but is not limited to housing, food (except meals provided while working), satisfaction of a debt, or a service provided by the employer for the employee.

b) Earned income in-kind shall be exempt.

(Source: Amended at 5 Ill. Reg. 10733, effective October l, l98l)

Section 120.376 Payments from the Illinois Department of Children and Family Services

Foster Care Payments

a) The following foster care payments made by the Department of Children and Families Services (DCFS) are to be considered exempt unearned income when determining the eligibility of the assistance unit (exclusive of the foster child).

1) Basic maintenance payments.

2) Special service fee payments.

3) Intensive service fee payments.

4) Monthly retainer fee payments.

5) Adoption Subsidies.

b) Independent living arrangement payments.
Payments made by DCFS to wards living independently of a foster home shall be considered nonexempt unearned income when determining the eligibility of the ward's children for assistance.

(Source: Amended at 8 Ill. Reg. 5253, effective April 9, l984)

Section 120.379 Provisions for the Prevention of Spousal Impoverishment

a) The provisions for the prevention of spousal impoverishment apply only to an institutionalized person (as defined in Section 120.388(c)) whose spouse resides in the community. For purposes of this Section, those persons shall be referred to as the institutionalized spouse and the community spouse.

b) Income. In determining the financial eligibility of an institutionalized spouse, only non-exempt income attributed to the institutionalized spouse shall be considered available. The following rebuttable presumptions shall apply in determining the income attributed to each spouse:

1) if payment of income is made solely in the name of one spouse, the income will be considered available only to that spouse;

2) if payment of income is made in the names of both spouses, one-half of the income shall be considered available to each spouse;

3) if payment of income is made in the names of either spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made to both spouses and no other interest is specified, one-half of the joint interest shall be considered available to each spouse);

4) if payment of income is made from a trust, the income shall be considered available to each spouse as provided under Section 120.347(h); and

5) if there is no trust or instrument establishing ownership, one-half of the income shall be considered available to the institutionalized spouse and one-half to the community spouse.

c) Resources. In determining the financial eligibility of an institutionalized spouse, the following shall apply:

1) At the beginning of a continuous period of institutionalization, the total value of resources owned by either or both spouses shall be computed.

2) Assessment. Upon the request of an institutionalized spouse, community spouse, or a representative of either, at the beginning of a continuous period of institutionalization, the Department shall conduct an assessment of the couple's resources for the purpose of determining the combined amount of nonexempt resources in which either spouse has an ownership interest. The person requesting the assessment shall be responsible for

providing documentation and verification necessary for the Department to complete the assessment.

3) For purposes of this subsection (c), a continuous period of institutionalization is defined as at least 30 days of continuous institutional care. An initial assessment remains effective during that period if:

A) a resident of a long term care facility is discharged for a period of less than 30 days and then reenters the facility;

B) a resident of a long term care facility enters a hospital and then returns to the facility from the hospital;

C) a person discontinues receiving home and community-based services for a period of less than 30 days; or

D) a person discontinues receiving home and community-based services due to hospitalization and then is discharged and begins to receive home and community-based services.

4) At the time of an institutionalized spouse's application for medical assistance, all nonexempt resources held by either the institutionalized person, the community spouse, or both shall be considered available to the institutionalized spouse. From this amount may be deducted and transferred to the community spouse the Community Spouse Resource Allowance (CSRA), as provided under subsection (d) of this Section. The remaining amount shall be the total amount of resources considered available to the institutionalized spouse.

d) Transfer of Resources to the Community Spouse. From the amount of nonexempt resources considered available to the institutionalized spouse, as described in subsection (c)(4) of this Section, a transfer of resources is allowed by the institutionalized spouse to the community spouse or to another individual for the sole benefit (as defined in Section 120.388(m)(2)(B)) of the community spouse in an amount that does not exceed the CSRA. The CSRA is the difference between the amount of resources otherwise available to the community spouse and the greatest of:

1) the amount established annually by the US Department of Health and Human Services (DHHS) (as of January 1, 2011, $109,560);

2) the amount established through a fair hearing under subsection (f)(3) of this Section; or

3) the amount transferred under a court order against an institutionalized spouse for the support of the community spouse.

e) Deductions are allowed from an institutionalized spouse's post-eligibility income (pursuant to Section 120.61(d) and (e)) for a community spouse income allowance and a family allowance. The deductions are determined as follows:

1) Community Spouse Maintenance Allowance.

A) The amount of monthly income that may be deducted from the institutionalized spouse's post-eligibility income for the benefit of the community spouse is equal to the minimum monthly maintenance needs allowance (MMMNA) less the amount of monthly income otherwise available to the community spouse (as determined under subsection (b) of this Section.The amount established as the MMMNA (as of January 1, 2011, $2,739 per month) shall be provided for calendar years after 2011 by DHHS.

B) The deduction is allowed only to the extent the income of the person is in fact contributed to the community spouse. However, the deduction for the community spouse income allowance shall not be less than the amount ordered by a court for support of the community spouse or the amount determined as the result of a fair hearing provided for under subsection (f) of this Section.

C) For purposes of this Section, all income of the institutionalized spouse that can be made available to the community spouse shall be made available before resources may be transferred in excess of the CSRA specified under subsection (d)(1) of this Section that will generate income to make up the difference between the MMMNA and the amount of income available to the community spouse.

2) Family Allowance. The amount of monthly income that may be deducted from the institutionalized spouse's post-eligibility income for the benefit of each family member is equal to one-third of the difference between the family maintenance needs standard (150% of the annual Federal Poverty Level for two persons) and any nonexempt income of the family member. Family members only include dependent children under age 21, dependent adult children, dependent parents or dependent siblings of either spouse who reside with the community spouse.

3) A deduction is also allowed from the institutionalized spouse's post-

eligibility income for dependent children under age 21 who do not reside with the community spouse pursuant to Section 120.61(e)(5).

4) The term "dependent" has the meaning ascribed to a "qualified" person under 26 USC 152.

f) Fair Hearings. Either the institutionalized spouse or the community spouse may request a hearing (as described in 89 Ill. Adm. Code 104.1) under this Section for the following reasons:

1) either spouse is dissatisfied with a determination of:

A) the community spouse income allowance under subsection (e)(1) of this Section;

B) the amount of the monthly income treated as otherwise available to the community spouse (as applied under subsection (e)(1) of this Section);

C) the attribution of resources under subsection (c)(4) of this Section; or

D) the determination of the CSRA under subsection (d) of this Section.

2) Either spouse may request an increase in the MMMNA under subsection (e)(1). If either spouse establishes that, due to exceptional circumstances resulting in significant financial duress, the community spouse needs income above the level provided by the MMMNA, an amount adequate to provide that additional income shall be substituted. For purposes of this subsection (f)(2), significant financial distress means expenses that the community spouse incurs in excess of the income standard, including:

A) recurring or extraordinary medical expenses of the community spouse that are not covered by any third party resource, including insurance or the Medical Assistance Program;

B) amounts necessary to preserve, maintain or make major repairs to homestead property; or

C) amounts necessary to preserve an income producing resource, subject to the limitations on that property under Section 120.381(a)(3) and as long as the expense is reasonable in relation

to the income produced by the resource.

3) Either spouse may request that an alternative CSRA be substituted for the standard CSRA calculated under subsection (d) of this Section if it can be established that the standard CSRA (in relation to the amount of income it generates) is inadequate to raise the community spouse's income to the MMMNA.

A) Before a substitute CSRA may be allocated under this subsection (f)(3), the amount of income attributed to the institutionalized spouse that may be transferred to the community spouse under subsection (e) of this Section shall first be considered available to raise the community spouse's income to the MMMNA.

B) If the sum of income otherwise available to the community spouse and income that may be transferred from the institutionalized spouse is insufficient to raise the community spouse's income to the MMMNA, then a substitute CSRA may be allowed. The amount the substitute CSRA may exceed the CSRA provided for under subsection (d) of this Section is limited to the amount of resources necessary to generate income to raise the community spouse's total income to the MMMNA.

C) In determining the amount of income that a substitute CSRA under this subsection (f)(3) may generate, the Department will use, for purposes of comparison, the cost to purchase an actuarially sound single premium life annuity producing monthly payments that, when added to the community spouse's total income, will be sufficient to raise the community spouse's income to, but not more than, the MMMNA. If resources are insufficient to purchase an annuity that will raise the community spouse's income to the MMMNA, the Department will measure the amount of an allowable increase in the CSRA by the cost to purchase an actuarially sound single premium life annuity producing monthly payments using available resources.

D) It is the requesting person's responsibility to provide the Department with an estimate from a reputable company of the cost to purchase the annuity described in subsection (f)(3)(C).

E) The Department may compare the estimate with available information on the cost of other single premium life annuities.

F) In calculating the amount of the community spouse's income after approval of a substitute CSRA, the Department shall deem the amount of the monthly annuity payments as being available to the community spouse, although it will not require the actual purchase of an annuity.

g) The appeal hearing described in subsection (d)(2) of this Section shall be held within 30 days after the date the appeal is filed.

h) A transfer of resources under subsection (d) of this Section from the institutionalized spouse to the community spouse shall be made as soon as practicable after the date of initial determination of eligibility and before the first regularly scheduled redetermination of eligibility, taking into account such time as may be necessary to obtain a court order under subsection (d)(3) of this Section. If a transfer of resources to a community spouse has not been made by the first scheduled redetermination and no petition for an order of spousal support is pending judicial review, the resources shall be considered available to the institutionalized spouse.

i) Assignment of Support Rights. The institutionalized spouse shall not be ineligible by reason of resources determined under subsection (c)(4) to be available for the cost of care when:

1) the institutionalized spouse has assigned to the State any rights to support from the community spouse (see Section 120.319);

2) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the State has the right to bring a support proceeding against a community spouse without that assignment; or

3) the State determines that denial of eligibility would work an undue hardship (see Section 120.388(r)(1)).

j) The Department may pursue any available legal process to enforce its right of assignment to support against the community spouse or any other responsible person pursuant to Section 120.319. These processes may include, but shall not be limited to, the administrative support procedures provided under 89 Ill. Adm. Code 103.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.380 Resources

a) Unless otherwise specified and for purposes of this Part, the term "resource" (as defined in 42 USC 1382b, except subsection (a)(1) of that section, which excludes the home as a resource) means cash or any other personal or real property that a person owns and has the right, authority or power to liquidate.

b) A resource is considered available to pay for a person's own care when at the disposal of that person; when the person has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance or medical care; or when the person has the lawful power to make the resource available or to cause the resource to be made available.

c) The value of nonexempt resources shall be considered in determining eligibility for any means-tested public benefit program administered by the Department, the Department of Human Services or the Department on Aging if eligibility is determined, in part, on the basis of resources as provided under this Section.

d) Determination of Resources.

1) In determining initial financial eligibility for medical assistance, the Department considers nonexempt verified resources available to a person as of the date of decision on the application for medical assistance. The date of verification (see Section 120.308(f)) may be prior to the date of decision. Resources applied to a spenddown obligation in a retroactive month (see Section 120.61(b)) shall not be treated as available in the determination of initial financial eligibility. Money considered as income for a month is not considered a resource for that same month. If income for a month is added to a bank account that month, the Department will subtract the amount of income from the bank balance to determine the resource level. Any income remaining in the following months is considered a resource.

2) In determining financial eligibility for retroactive months, the Department will consider the amount of income and resources available to a person as of the first day of each of the backdated months for which eligibility is sought. Resources spent prior to the end of the month of application to purchase a Pre-paid Funeral/Burial Contract in compliance with Section 120.381(b), (c) or (d), to pay for incurred medical expenses or to pay legal fees up to $10,000 (which shall be adjusted annually for any increase in the Consumer Price Index), incurred in the month of application or in any of the three months prior to the month of application, that are related to the

eligibility application for long term care assistance shall not be considered available.

3) In determining a person's spenddown obligation (see Section 120.384), the Department considers the amount of nonexempt resources available as of the date of decision, in the case of initial eligibility, and the first day of the month, in the case of retroactive eligibility, that are in excess of the applicable resource disregard (see Section 120.382).

e) Subject to subsection (c) of this Section and 89 Ill. Adm. Code 113.140, the entire equity value of jointly held resources shall be considered available in determining a person's eligibility for assistance, unless:

1) The resource is a joint income tax refund, in which case one-half of the refund is considered owned by each person; or

2) The person documents that he or she does not have access to the resource. Appropriate documents may include, but are not limited to, bank documents, signature cards, trust documents, divorce papers, and papers from court proceedings that show the person is legally unable to access the resource; or

3) The resource is held jointly with an individual eligible under any means-tested public health benefit program (other than the Supplemental Nutrition Assistance Program) administered by the Department, the Department of Human Services, or the Department on Aging; or

4) The person can document the amount of his or her legal interest in the resource and that such amount is less than the entire value of the resource, then the documented amount shall be considered. Appropriate documentation may include, but is not limited to, bank documents, trust documents, signature cards, divorce papers, or court orders that show the person's legal interest is less than the entire value of the resource; or

5) The person documents that the resource or a portion of the resource is not owned by the person and the person's accessibility to the resource is changed (see subsections (e)(2) and (4) of this Section for documentation examples).

f) In determining the eligibility of a person for long term care services whose spouse resides in the community, all nonexempt resources owned by the institutionalized spouse, the community spouse, or both shall be considered available to the institutionalized spouse in determining his or her eligibility for medical

assistance. From the total amount of such resources may be deducted a Community Spouse Resource Allowance as provided under Section 120.379.

g) Trusts established prior to August 11, 1993 shall be treated in the manner described in Section 120.346.

h) Trusts established on or after August 11, 1993 shall be treated in the manner described in Section 120.347.

i) The value of a life estate shall be determined at the time the life estate in the property is established and at the time the property (for example, resources) is liquidated. In determining the value of a life estate and remainder interest based on the value of the property at the time the life estate is established or of the amount received when the property is liquidated, the Department shall apply the values described in Section 120.Table A. The life estate and remainder interest are based on the age of the person at the time the life estate in the property is established and at the time the property is liquidated and the corresponding values described in Section 120.Table A.

j) A person's entrance fee in a continuing care retirement community or life care community (as those entities are described in 42 USC 1396r(c)(5)(B)) shall be considered an available resource to the extent that:

1) the person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used to pay for care should other resources or income of the person be insufficient to pay for the care;

2) the person is eligible for a refund of any remaining entrance fee when the person dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

3) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

k) Non-homestead real property, including homestead property that is no longer exempt (see Section 120.381(a)(1)), is considered an available resource unless:

1) the property is exempted as income-producing to the extent permitted under Section 120.381(a)(3), except Section 120.381(a)(3) shall not apply to farmland property and personal property used in the income-producing operations related to the farmland (e.g., equipment and supplies, motor vehicles, tools, etc.);

2) ownership of the property consists of a fractional interest of such a small value that a substantial loss to the person would occur if the property were sold;

3) the property has been listed for sale, in which case the property will not be counted as available for at least six months as long as the person continues to make a good faith effort to sell the property. This effort can be verified by evidence, including advertisements or documentation of the listing of the property with licensed real estate agents or brokers that includes a report of any offer from prospective buyers. The Department will review cases in which the property has not been sold after six months and will consider the following factors in determining if extensions of the initial six months are warranted:

A) the asking price is less than the fair market value of the property;

B) the property is marketed through a qualified realtor who is acting in good faith;

C) there is not a substantial market for the type of property being sold; and

D) the person has not rejected any reasonable offer to buy the property; or

4) the homestead property that is no longer exempt (see Section 120.381(a)(1)) is producing annual net income for the person in an amount that is not less than six percent of the person's equity value in the property. In determining net income, the Department shall recognize business expenses allowed for federal income tax purposes.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.381 Exempt Resources

a) The following resources are exempt from consideration in determining eligibility for medical assistance:

1) Homestead Property.

A) Homestead property is any property in which a person (and spouse, if any) has an ownership interest and that serves as the person's principal place of residence. This property includes the shelter in which a person resides, the adjoining land on which the shelter is located and related outbuildings.

B) If a person (and spouse, if any) moves out of his or her home without the intent to return, the home is no longer exempt because it is no longer the person's principal place of residence. If a person leaves his or her home to live in a long term care facility, the property is considered exempt, irrespective of the person's intent to return, as long as a spouse or dependent relative of the eligible person continues to live there. The person's equity in the former home is treated as an available resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

2) Personal effects and household goods are exempt to the extent they are excluded under 20 CFR 416.1216.

3) Resources (for example, land, buildings, equipment and supplies or tools) necessary for self-support up to $6,000 of the person's equity in the income producing property provided the property produces a net annual income of at least six percent of the excluded equity value of the property. The equity value in excess of $6,000 is not excluded. If the activity produces income that is less than six percent of the exempt equity due to reasons beyond the person's control (for example, the person's illness or crop failure) and there is a reasonable expectation that the property will again produce income equal to six percent of the equity value (for example, a medical prognosis that the person is expected to respond to treatment or that drought resistant corn will be planted), the equity value in the property up to $6,000 is exempt. If the person owns more than one piece of property and each produces income, each is looked at to determine if the six percent rule is met and then the amounts of the person's equity in all of those properties are totaled to see if the total equity is $6,000 or less. The total equity value of all properties that is

exempt under this subsection is limited to $6,000.

4) Automobile.

A) Exclude one automobile, regardless of value, used by the client, spouse or other dependent if:

i) it is necessary for employment;

ii) it is necessary for the medical treatment of a specific or regular medical problem;

iii) it is modified for operation by, or transportation of, a handicapped person;

iv) it is necessary because of factors such as climate, terrain or distance to provide necessary transportation to perform essential daily activities; or

v) one vehicle for each spouse is exempt in determining the amount allowed as the Community Spouse Resource Allowance (as described in Section 120.379(d)).

B) If not excluded in subsection (a)(4)(A) of this Section, one automobile is excluded to the extent its equity value does not exceed $4500. Any excess equity value is applied toward the applicable resource disregard (see Section 120.382).

C) For all other automobiles, apply the equity value toward the resource disregard (see 89 Ill. Adm. Code 113.142).

5) Life insurance policies with a total face value of $1,500 or less and all term life insurance policies. If the total face value exceeds $1,500, the cash surrender value must be counted as a resource.

6) For purposes of this Section, the term "equity value" refers to:

A) in the case of real property, the value described in Section 120.385(c); and

B) in the case of personal property, the price that an item can reasonably be expected to sell for on the open market in the particular geographic area involved, minus any encumbrances (as

described in Section 120.385(c)(1)(C)).

b) Burial spaces that are intended for the use of the person, his or her spouse, or any other member of his or her immediate family are exempt. Immediate family is defined as a person's minor and adult children, including adopted children and stepchildren, a person's brothers, sisters, parents and adoptive parents, and the spouses of these individuals.

c) Funds that are set aside for the burial expenses of a person and his or her spouse in a bank account owned by the person that is clearly identified as a burial fund is exempt up to $1500. This amount is reduced by the face value of any excluded life insurance on the person and the amount of any funds held in an irrevocable trust or other irrevocable arrangement that is available for burial expenses per person.

d) Prepaid Funeral/Burial Contracts. Prepaid funeral/burial contracts are exempt to the following extent:

1) Funds in a revocable prepaid funeral/burial contract are exempt up to $1500.

2) Effective January 1, 2012, funds in an irrevocable prepaid funeral/burial contract are exempt up to $10,000, which shall include the costs of both goods and services. This amount shall be adjusted annually for any increase in the Consumer Price Index.

3) A prepaid, guaranteed price funeral/burial contract up to $10,000, which shall include the costs of both goods and services and which shall be adjusted annually for any increase in the Consumer Price Index, funded by an irrevocable assignment of a person's life insurance policy to a trust, is exempt. The trust is responsible for ensuring that the provider of funeral services under contract receives the proceeds of the policy when it provides the funeral goods and services specified under the contract. The irrevocable assignment of ownership of the insurance policy must be acknowledged by the insurance company.

e) Resources necessary for fulfillment of an approved plan for achieving self-support under 42 CFR 416.1220.

f) Resources excluded by express provision of 20 CFR 416.1236 (2009).

g) *Donations or benefits from fund raisers held for a seriously ill client provided the client or a responsible relative of the client does not have control* (for example,

not available to the client or the responsible relative) *over the donations or benefits or the disbursement of donations or benefits* [305 ILCS 5/5-2].

h) Payments made to veterans who receive an annual disability payment or to the survivors of deceased veterans who receive a one-time lump sum payment from the Agent Orange Settlement Fund or any other fund referencing Agent Orange product liability under Public Law 101-201.

i) Money received from the Social Security Administration under a Plan to Achieve Self-Support (PASS) and held in a separate account.

j) Disaster relief payments provided by federal, State or local government or a disaster assistance organization.

k) The amount of earned income tax credit that the client receives as advance payment or as a refund of federal income tax.

l) For disabled persons who have lost eligibility under Section 120.510 and who are only requesting services other than those described in Section120.61(a) (except that subsection's reference to services provided through a Community Integrated Living Facility (CILA)), the following additional exemptions shall apply:

1) Retirement accounts that a person with a disability cannot access without penalty before the age of 59½ and medical savings accounts established pursuant to 26 USC 220; and

2) Up to $25,000 if the person owned assets of equal value when his or her eligibility under Section 120.510 ended.

m) The amount of damages recovered by a resident of a nursing home for any act that injures the resident pursuant to 210 ILCS 45/3-605.

n) Certain payments received under the American Recovery and Reinvestment Act of 2009.

1) Payments to World War II veterans who served in the Philippines and spouses of those veterans under Div. A, Title X, Sec. 1002 of P.L. 111-5.

2) Payments or reimbursements for Premium Assistance for COBRA Continuous Coverage under Div. B, Title III, Sec. 3001 of P.L. 111-5.

o) Certain payments received under the American Recovery and Reinvestment Act of 2009 are exempt as an asset the month of receipt and two months thereafter.

1) Making Work Pay Credit under Div. B, Title I, Sec. 1001 of P.L. 111-5.

2) Tax Credit for Certain Government Retirees under Div. B, Title II, Sec. 2202 of P.L. 111-5.

p) Economic Recovery Payments under the American Recovery and Reinvestment Act of 2009 under Div B, Title II, Sec. 2201 of P.L. 111-5 are exempt as an asset the month of receipt and nine months thereafter.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.382 Resource Disregard

In addition to the exempt resources listed in Section 120.381, the cash value of resources shall be disregarded for AABD MANG as follows:

a) $2,000 for a person and $3,000 for a person and one dependent residing together. A dependent means a "qualifying" person as that term is described in 26 USC 152.

b) $50 for each additional dependent residing in the same household.

c) Resources equal in amount to the benefits paid on behalf of a person under a qualified long term care insurance policy as provided under 42 USC 1396p(b)(1)(C) and (b)(5). Policies written in Illinois are approved by the Director of the Illinois Department of Insurance under the Qualified Long Term Care Insurance Partnership (QLTCIP) program (50 Ill. Adm. Code 2012). The dollar value of the amount paid for QLTCIP benefits is disregarded; the extent to which the disregard is applied to a resource will depend and may vary with the underlying equity value (see Section 120.381(a)(6)) the person holds in the resource.

d) Eligibility for medical assistance or the benefits described in Sections 120.72 and 120.73 does not exist when nonexempt resources exceed allowable disregards.

e) For Qualified Medicare Beneficiaries (QMB)

1) $4,000 for a single person and $6,000 for a person with one or more dependents.

2) Eligibility for QMB status does not exist when resources exceed the disregard amounts described in this subsection (e).

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.383 Deferral of Consideration of Assets

a) Consideration of excess assets may be deferred for a period not to exceed two months for applicants who are leaving a State School or State mental hospital to enter group care facilities and for whom the exact trust fund amount cannot be determined but appears not to exceed one month's needs.

b) A final decision concerning use or disposal of nonexempt assets may be deferred for 90 days, from the date assistance is initially authorized, when it can be assumed at the time of application that the period of eligibility will not extend beyond 90 days.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

Section 120.384 Spenddown of Resources

In determining a person's resource spenddown obligation, the Department compares nonexempt resources available to the person to the appropriate resource disregard. The amount of resources in excess of the disregard determines the amount of the spenddown.

a) If a person presents verification that excess resources are no longer available, the Department will make the appropriate changes the month following the month the person disposed of the resources.

b) Persons enrolled in spenddown are not eligible for payment of covered medical services until spenddown is met. A resource spenddown is met by presenting allowable medical bills or receipts to the Department that equal the amount of the person's nonexempt excess resources. See Sections 120.60(c) and 120.61(c) for specific requirements related to spenddown, including the option to pay in spenddown to the Department by enrolling in the Pay-in Spenddown Program.

c) Once an excess resource has been used to meet spenddown, whether or not the excess amount has actually been reduced, it is no longer considered. However, at reapplication/redetermination, the Department will consider any excess nonexempt resources remaining as currently available.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.385 Factors Affecting Eligibility for Long Term Care Services

a) For purposes of this Section, the terms "institutionalized persons" and "long term care services" shall have the meanings described in Section 120.388 of this Part. The terms "institutionalized spouse" and "community spouse" shall have the meanings described in Section 120.379(a) of this Part.

b) Disclosure of Annuity and Naming the State as Remainder Beneficiary.

1) Effective January 1, 2012, an application (or redetermination related to an application) for long term care services shall include a disclosure by an institutionalized person or his or her community spouse of any interest either or both may have in any annuity or similar financial instrument purchased, regardless of whether the annuity is irrevocable or is treated as an asset. The application or recertification form shall also include a statement that the State of Illinois becomes a remainder beneficiary under such an annuity or similar financial instrument to the extent that the State has provided medical assistance to the institutionalized person.

2) Failure of an institutionalized person, his or her community spouse, or his or her representative to disclose information or to name the State as a remainder beneficiary as provided for in subsection (b)(1) of this Section, or to disclose sufficient information regarding an annuity in order to establish eligibility for long term care services, shall result in denial or termination of the eligibility. Failure of an institutionalized person, his or her community spouse or his or her representative to disclose the information provided for in subsection (b)(1) of this Section, or to disclose sufficient information regarding an annuity in order to establish eligibility for medical assistance, may also result in denial or termination of eligibility for failure to cooperate under Section 120.308.

c) Home Equity Interest.

1) Effective January 1, 2012, a person shall not be eligible for long term care services if the person's equity interest in his or her homestead exceeds $750,000. This amount shall be increased, beginning with 2013, from year to year based on the percentage increase in the Consumer Price Index for all urban consumers (all items: United States city average), rounded to the nearest $1000. A person's equity interest in his or her homestead shall be determined as follows:

A) The current market value (CMV) of the property is the going price for which it can reasonably be expected to sell on the open market

in the particular geographic area involved. The CMV of the property may be established by:

i) an appraisal report, no more than six months old at the time of the application for long term care services, completed by an appraiser who is licensed or otherwise meets the requirements under the Real Estate Appraiser Licensing Act [225 ILCS 458]; or

ii) a county real estate assessor's current estimate of the market value or fair cash value of the property used in determining the assessed value of a property; or

iii) any other reliable and verifiable indicia of the price that a property would bring in a sale between a willing buyer and seller under arms-length conditions unaffected by undue pressures;

B) Equity value (EV) is the CMV of the property minus any encumbrance on it;

C) An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property but does not necessarily prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell, the creditor will nearly always require debt satisfaction from the proceeds of sale. Examples of encumbrances include mortgages, reverse mortgages, home equity loans or other debt that is secured by the property;

D) If property is held in any form of shared ownership (e.g., joint tenancy, tenancy in common or other similar arrangement) only the fractional interest in the property shall be considered in determining the person's equity in that property.

2) The eligibility of a person for long term care services shall not be affected under this subsection (c) if any of the following are lawfully residing in the person's home:

A) the person's spouse;

B) the person's child who is under age 21; or

C) the person's adult child who is blind (as described in Section 120.313 of this Part) or disabled (as described in Section 120.314 of this Part).

3) A person whose eligibility for long term care services is affected under this subsection (c) may request a hardship waiver. The process and basis for requesting such a waiver shall be the same as described in Section 120.388(r) of this Part. In determining whether a waiver should be granted, the Department shall also take into account:

A) the amount of time the person has resided in and owned the home;

B) whether a substantial increase in property values in the home's geographic area occurred after the person purchased the home;

C) whether the home comprises a substantial portion of the person's assets (as defined in Section 120.388(d)); and

D) whether the person intends to return to the home after a period of institutionalization or, if the person does not intend to return, whether the home can be sold after being listed for sale or, if it cannot be sold, can produce income commensurate with similar income producing properties in the geographic area.

4) For purposes of this Section the words, "homestead" and "home" have the same meaning as the term "homestead" in Section 120.381(a)(1)(A) of this Part.

d) Disclosure of Purchase of Promissory Notes, Loans and Mortgages and Assigning Interest to the State.

1) Effective January 1, 2012, an application (or redetermination related to an application) for long term care services shall include a disclosure by an institutionalized person or his or her community spouse of any purchase of a promissory note, loan or mortgage either or both may have made. The application or recertification form shall also include a statement that the instrument shall provide for the assignment to the State of Illinois, as of the date of death, of up to the total amount of medical assistance paid on behalf of the institutionalized person.

2) Failure of an institutionalized person, his or her community spouse, or his or her representative to disclose information or to assign interest to the State as provided for in subsection (d)(1) of this Section, or to disclose

sufficient information regarding a promissory note, loan or mortgage in order to establish eligibility for long term care services, shall result in denial or termination of the eligibility. Failure of an institutionalized person, his or her community spouse, or his or her representative to disclose the information provided for in subsection (d)(1) of this Section, or to disclose sufficient information regarding a promissory note, loan or mortgage in order to establish eligibility for medical assistance, may also result in denial or termination of eligibility for failure to cooperate under Section 120.308.

(Source: Section repealed at 17 Ill. Reg. 1102, effective January 15, 1993; new Section adopted at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.386 Property Transfers Occurring On or Before August 10, 1993

a) Applicability

1) The provisions for the transfer of property (for example, assets) in this Section only apply to institutionalized persons when the transfer occurs on or before August 10, 1993. An institutionalized person is defined as a resident of a long term care facility, including a resident who was living in the community at the time of the transfer, and to individuals who but for the provision of home and community-based services under Section 4.02 of the Illinois Act on the Aging would require the level of care in a long term care facility. An institutionalized person also includes an individual receiving home and community-based services under Section 4.02 of the Illinois Act on the Aging who was not receiving these services at the time of the transfer.

2) Transfers of property disregarded as a result of payments made by a Long Term Care Partnership Insurance Policy (as described in 50 Ill. Adm. Code 2018) are not subject to the provisions of subsections (b), (c), and (d) of this Section.

3) The provisions for the transfer of property (for example, assets) in this Section apply to the transfer of property by the institutionalized person's spouse in the same manner as if the institutionalized person transferred the property.

b) A transfer of assets occurs when an institutionalized person or an institutionalized person's spouse buys, sells or gives away real or personal property or changes (for example, change from joint tenancy to tenancy in common) the way property is held. Changing ownership of property to a life estate interest is an asset transfer (the value of the life estate and remainder interest is determined as described in Section 120.380 and 89 Ill. Adm. Code 113.140). A transfer occurs when an action or actions are taken which would cause an asset or assets not to be received (for example, waiving the right to receive an inheritance).

c) A transfer is allowable if:

1) the transfer occurred more than 30 months before the date of application or more than 30 months before entry into the long term care facility or more than 30 months before receipt of services provided by the Illinois Department on Aging under the In-Home Care Program (as described in Section 140.643);

2) a fair market value was received. Fair market value is the price that an article or piece of property might be expected to bring if offered for sale in a fair market. Fair market value is determined by statements obtained from institutions, community members, etc. (for example, bankers, jewelers, reputable realtors, etc.) recognized as having knowledge of property values;

3) homestead property was transferred to:

A) a spouse;

B) the individual's child who is under age 21;

C) the individual's child who is blind or permanently and totally disabled;

D) the individual's brother or sister who has an equity interest in the homestead property and who was residing in the home for at least one year immediately prior to the date the individual became institutionalized; or

E) the individual's child who provided care for the individual and who was residing in the homestead property for two years immediately prior to the date the individual became institutionalized;

4) the transfer by the institutionalized person was to the community spouse or to another individual for the sole benefit of the community spouse and the amount transferred does not exceed the Community Spouse Asset Allowance (as described in Section 120.379);

5) the transfer was to the individual's child who is blind or permanently and totally disabled or to another person for the sole benefit of the individual's child;

6) the individual intended to transfer the assets for fair market value;

7) it is determined that denial of assistance would create an undue hardship. Examples of undue hardship include, but are not limited to, situations in which:

A) the individual is mentally unable to explain how the assets were transferred;

B) the denial of assistance would force the resident to move from the long term care facility; or

C) the individual would be prohibited from joining a spouse in a facility or would prohibit the individual from entering a facility that is within close proximity to his/her family;

8) the transfer was made exclusively for a reason other than to qualify for assistance. A transfer for less than fair market value is presumed to have been made to qualify for assistance unless a satisfactory showing is made to the Department that the client or spouse transferred the asset exclusively for a reason other than to qualify for assistance;

9) the transfer by the individual was to the community spouse and was the result of a court order; or

10) the transfer was to an annuity and the expected return on the annuity is commensurate with the estimated life expectancy of the person. In determining the estimated life expectancy of the person, the Department shall use the life expectancy table described in Section 120.Table B.

d) If a transfer or transfers do not meet the provisions of subsection (c), the client is subject to a period of ineligibility for long term care services and for services provided by the Illinois Department on Aging under the In-Home Care Program (as described in Section 140.643). The penalty period is determined in accordance with subsection (e). If otherwise eligible, clients remain entitled to other covered medical services.

e) A separate penalty period is determined for each month in which a transfer or transfers do not meet the provisions of subsection (c). Each penalty period is the lesser of the number of months the total uncompensated amount of the transferred assets would meet the monthly cost of long term care at the private rate or 30 months.

f) The penalty period begins with the month of the transfer or transfers unless the transfer or transfers occurred during a previous penalty period. If so, the penalty period begins with the month following the month the previous penalty period ends. However, the penalty period cannot exceed 30 months from the month of the transfer or transfers.

(Source: Amended at 19 Ill. Reg. 15079, effective October 17, 1995)

Section 120.387 Property Transfers Occurring On or After August 11, 1993 and Before January 1, 2007

a) The provisions for the transfer of assets listed in subsection (e) only apply to institutionalized persons when the transfer occurs on or after August 11, 1993 and before January 1, 2007 or to persons who applied for or whose application for long term care assistance was filed or approved prior to January 1, 2012. An institutionalized person is defined as a resident of a long term care facility, including a resident who was living in the community at the time of the transfer, and to individuals who but for the provision of home and community-based services under Section 4.02 of the Illinois Act on the Aging would require the level of care in a long term care facility. An institutionalized person also includes an individual receiving home and community-based services under Section 4.02 of the Illinois Act on the Aging who was not receiving these services at the time of the transfer.

b) The provisions for the transfer of property (e.g., assets) listed in subsection (e) apply to the transfer of property by the institutionalized person's spouse in the same manner as if the institutionalized person transferred the property.

c) Transfers of property disregarded as a result of payments made by a Long Term Care Partnership Insurance Policy (as described in 50 Ill. Adm. Code 2018) are not subject to the provisions of this Section.

d) A transfer of assets occurs when an institutionalized person or an institutionalized person's spouse buys, sells or gives away real or personal property or changes (for example, change from joint tenancy to tenancy in common) the way property is held. Changing ownership of property to a life estate interest is an asset transfer (the value of the life estate and remainder interest is determined as described at Section 120.380 and 89 Ill. Adm. Code 113.140). For assets held in joint tenancy, tenancy in common or similar arrangement, a transfer occurs when an action by any person reduces or eliminates the person's ownership or control of the asset. A transfer occurs when an action or actions are taken that would cause an asset or assets not to be received (e.g., waiving the right to receive an inheritance).

e) A transfer is allowable if:

1) depending on the property transferred, the transfer occurred more than either 60 or 36 months before the date of application, or more than either 60 or 36 months before entry into a long term care facility or more than either 60 or 36 months before receipt of services provided by the Illinois

Department on Aging under the In-Home Care Program (as described in 89 Ill. Adm. Code 140.643);

A) the 60 month period applies to payments from a revocable trust that are not treated as income (as described in Section 120.347) and to portions of an irrevocable trust from which no payments could be made (as described in Section 120.347);

B) the 36 month period applies to payments from an irrevocable trust that are not treated as income (as described in Section 120.347) and to any other property transfers not identified in this subsection;

2) a fair market value was received. Fair market value is the price that an article or piece of property might be expected to bring if offered for sale in a fair market. Fair market value is determined by statements obtained from institutions, community members, etc. (e.g., bankers, jewelers, reputable realtors, etc.) recognized as having knowledge of property values;

3) homestead property was transferred to:

A) a spouse;

B) the person's child who is under age 21;

C) the person's child who is blind (as described in Section 120.313) or disabled (as described in Section 120.314);

D) the person's brother or sister who has an equity interest in the homestead property and who was residing in the home for at least one year immediately prior to the date the person became institutionalized; or

E) the person's child who provided care for the person and who was residing in the homestead property for two years immediately prior to the date the person became institutionalized;

4) the transfer by the institutionalized person was to the community spouse or to another person for the sole benefit of the community spouse;

5) the transfer from the community spouse was to another person for the sole benefit of the community spouse;

6) the transfer was to the person's child or to a trust established solely for the benefit of the person's child who is blind (as described in Section 120.313) or disabled (as described in Section 120.314) or to another person for the sole benefit of the person's child;

7) the transfer was to a trust established solely for the benefit of a person under age 65 who is disabled (as described in Section 120.314);

8) the person intended to transfer the assets for fair market value;

9) it is determined that denial of assistance would create an undue hardship. Examples of undue hardship include, but are not limited to, situations in which:

A) the individual is mentally unable to explain how the assets were transferred;

B) the denial of assistance would force the resident to move from the long term care facility; or

C) the individual would be prohibited from joining a spouse in a facility or would prohibit the individual from entering a facility that is within close proximity to his or her family;

10) the transfer was made exclusively for a reason other than to qualify for assistance. A transfer for less than fair market value is presumed to have been made to qualify for assistance unless a satisfactory showing is made to the Department that the client or spouse transferred the asset exclusively for a reason other than to qualify for assistance;

11) the transfer by the client was to the community spouse and was the result of a court order;

12) the assets transferred for less than fair market value have been returned to the person; or

13) the transfer was to an annuity, the expected return on the annuity is commensurate with the estimated life expectancy of the person, and the annuity pays benefits in approximately equal periodic payments. In determining the estimated life expectancy of the person, the Department shall use the current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration

http://www.ssa.gov/OACT/STATS/table4c6.html.

f) If a transfer or transfers do not meet the provisions of subsection (e), the client is subject to a period of ineligibility for long term care services and for services provided by the Illinois Department on Aging under the In-Home Care Program (as described in Section 140.643). The penalty period is determined in accordance with subsection (g) of this Section. If otherwise eligible, clients remain entitled to other covered medical services.

g) A separate penalty period is determined for each month in which a transfer or transfers do not meet the provisions of subsection (e) of this Section. Each penalty period is the number of months equal to the total uncompensated amount of assets transferred during a month divided by the monthly cost of long term care at the private rate.

h) The penalty period begins with the month of the transfer or transfers unless the transfer or transfers occurred during a previous penalty period. If so, the penalty period begins with the month following the month the previous penalty period ends.

i) For transfers by the community spouse that result in a penalty period as described in subsection (g) of this Section and the community spouse becomes an institutionalized person and is otherwise eligible for assistance, the Department shall divide any remaining penalty period equally between the spouses.

(Source: Amended at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.388 Property Transfers Occurring On or After January 1, 2007

The provisions in this Section are intended to comport with federal requirements related to transfers of assets, in particular, requirements under 42 USC 1396p and guidance from the US Department of Health and Human Services related to those statutory requirements. Interpretation and application of this Section shall be made in light of those requirements.

a) General. A transfer of assets for less than fair market value made on or after January 1, 2007 by an institutionalized person or the spouse of that person within 60 months before the later of applying for medical assistance or transferring an asset shall result in a period of ineligibility for long term care services for that person.

b) Long term care services are defined as:

1) services provided in a long term care facility as that institution is defined in Section 120.61(a); and

2) services provided under a home and community based waiver authorized under 42 USC 1396n(c) or (d) and specified in 42 CFR 441 Subpart G or H.

c) Institutionalized individuals or persons are defined as:

1) persons residing in long term care facilities, including those who were residing in the community at the time a transfer of assets was made; or

2) persons who, but for the provision of home and community based waiver services (42 USC 1396a(a)(10)(A)(ii)(VI)), would require the level of care in a long term care facility, including those persons receiving home and community based waiver services who were not receiving the services at the time a transfer of assets was made.

d) Assets.

1) For purposes of this Section, the term "assets" or "property" includes all income (as defined in 42 USC 1382a) and resources (as defined in 42 USC 1382b, except subsection (a)(1) of that section, which excludes the home as a resource) of an institutionalized person and that person's spouse, including, but not limited to: cash; savings certificates; stocks; bonds; interests in real property, including mineral rights; rights to inherited real or personal property or income; and accounts and debts receivable.

2) Assets also include any income or resources that the person or the person's spouse is entitled to but does not receive because of action or inaction by:

A) the person or the person's spouse;

B) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse;

C) any person, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse; or

D) any person who acted (or failed to act) to avoid receiving assets to which the person was entitled.

3) Examples of actions that would cause assets not to be received include:

A) Irrevocably waiving pension income;

B) Waiving the right to receive an inheritance;

C) Not accepting or accessing injury settlements;

D) Arranging for a defendant in a civil action to divert a settlement amount into a trust or similar device for the benefit of the person, who is a plaintiff in the case;

E) Refusing to take legal action to obtain a court-ordered payment that is partially or wholly unpaid, such as alimony; or

F) Receiving an inheritance under a will when renouncing the will and taking a statutory share (see 755 ILCS 5/2-8) is more advantageous. Alternately, renouncing a will and taking a statutory share when taking the inheritance is more advantageous.

4) Failure to take action to receive an asset is not considered a transfer for less than fair market value when evidence is submitted showing the cost of obtaining an asset exceeds the value of the asset.

e) Transfer. A transfer of assets occurs when an institutionalized person or an

institutionalized person's spouse buys, sells or gives away real or personal property or changes (e.g., a change from joint tenancy to tenancy in common) the way property is held.

1) Changing ownership of property to a life estate interest is an asset transfer (the value of the life estate and remainder interest is determined as described in Section 120.380(i) and 89 Ill. Adm. Code 113.140(e)).

2) Transactions involving annuities, including the purchase of an annuity or any action by a person that changes the course of payments to be made by the annuity or the treatment of income or principal of the annuity, are considered transfers under this Section. Such actions include, but are not limited to, additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and any action intended to make an annuity irrevocable or nonassignable.

3) For property held in joint tenancy, tenancy in common or similar arrangement, a transfer occurs when an action by any person reduces or eliminates the person's ownership or control of the property.

4) A transfer of income in the month it is received is considered a transfer of assets if the income would have been considered an asset in the following month as provided under Section 120.380(d)(1). A transfer of the proceeds of a loan in the month received is considered a transfer of assets.

f) Fair market value (FMV) is an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred. Prevailing price is what property would sell for on the open market between a willing buyer and a willing seller, with neither being required to act and both having reasonable knowledge of the relevant facts.

1) In determining if FMV has been received for an asset, the Department shall use all reasonable means available and consider all relevant facts and circumstances relating to the asset and the transaction, including, but not limited to: the cost or price paid for the asset, whether the transaction was at arm's length, comparable sales, replacement cost, and expert opinion. In determining the FMV of farmland in Illinois, the Department may take into account market values determined under methodologies developed by the University of Illinois College of Agricultural, Consumer and Environmental Sciences.

2) For an asset to be considered transferred for FMV, the compensation

received for the asset must be in a tangible form with intrinsic value that is roughly equivalent to or greater than the value of the transferred asset.

3) Transfers of assets for "love and affection" are not considered transfers for FMV. A transfer to a friend, family member or relative for care provided for free in the past is a transfer of assets for less than FMV. The Department presumes that services, care or accommodations rendered to a person by a friend or family member are gratuitous and without expectation of compensation. This presumption may be rebutted by credible documentary evidence that preexists the delivery of the care, services or accommodations showing the type and terms of compensation and contemporaneous receipts, logs or other credible documentation showing actual delivery of the care or services claimed. Compensation paid in excess of prevailing rates for similar care, services or accommodations in the community shall be treated as a transfer for less than FMV.

4) "Compensation received" is the amount of money or value of any property or services received in return for the institutionalized person's assets. The compensation received may be in the form of:

A) Cash;

B) Other assets such as promissory notes, stocks, bonds, and both real estate contracts and life estates that are evaluated over an extended time period;

C) Discharge of a debt;

D) Prepayment of a bona fide and irrevocable contract, such as a mortgage, shelter lease, loan or prepayment of taxes;

E) Services; and

F) Any other act, object, service or other benefit that has tangible or intrinsic economic value to the person.

5) The term "uncompensated value" means the difference between the FMV of a transferred asset (less any outstanding loans, mortgages, or other encumbrances on the asset) and the actual compensation received. Only the uncompensated value of a transferred asset is subject to the penalty provisions described in this Section.

g) Look Back Period. The provisions of this Section apply to any asset transfers occurring on or after January 1, 2007, and before the date on which the person is an institutionalized person (as defined in subsection (c) of this Section) and has applied for medical assistance.

h) Penalty. If a person transfers assets for less than fair market value, the person is subject to a period of ineligibility for long term care services. The penalty period is determined in accordance with subsection (j) of this Section. If otherwise eligible, persons subject to a penalty remain eligible for all covered medical services except long term care services.

i) Penalty Period.

1) A penalty period under this Section:

A) begins with the later of:

i) the first day of a month during which a transfer for less than FMV is made; or

ii) the date on which the person is eligible for medical assistance and would otherwise be receiving long term care services (based on an approved application for those services) were it not for the imposition of the penalty period. A person is not considered eligible and services are not considered capable of being received under this subsection (i) until any spenddown is met; and

B) does not occur during any other period of ineligibility under this Section.

2) A notice of penalty period shall include a statement that the person may appeal the penalty period pursuant to 89 Ill. Adm. Code 102.80.

j) Penalty Calculation. A penalty period is determined based on the uncompensated value of transfers. The penalty period is calculated by dividing the total uncompensated value of assets transferred by the average monthly cost of long-term care services at the private rate in the community in which the person is institutionalized at the time of application. The result is the penalty period in number of months, days and portion of a day (e.g., $65,000/$4000 = 16.25 = 16 months and 7.5 days). The Department will not round down or otherwise

disregard any period of ineligibility calculated under this subsection.

k) Multiple Transfers. Multiple, non-allowable transfers made during the look-back period shall be cumulated and treated as a single transfer. A single period of ineligibility shall be calculated based on the total uncompensated value of the transfers. Once a penalty period is imposed, it continues to run without regard to whether the person continues receiving long term care services.

l) When transfers by a community spouse result in a penalty period for the institutionalized spouse and the community spouse subsequently becomes institutionalized and is otherwise eligible for medical assistance, the Department shall divide any remaining penalty period equally between the spouses. If one spouse predeceases the other before the penalty period has ended, the remaining penalty period will be added to the surviving spouse's penalty.

m) A person shall not be subject to a penalty period under this Section to the extent that:

1) homestead property was transferred to:

A) the person's spouse;

B) the person's child who is under age 21;

C) the person's child who is determined blind (as described in Section 120.313) or determined disabled (as described in Section 120.314);

D) the person's brother or sister who has an equity interest in the homestead property and who was residing in the home for at least one year immediately prior to the date the person became institutionalized; or

E) the person's son or daughter who provided care for the person and who resided in the homestead property for the two years immediately prior to the date the person became institutionalized provided credible tangible evidence is presented that:

i) shows the person was in need of care that would have otherwise required an institutional level of care. The evidence may consist of a physician's statement or an evaluation conducted by a medical professional showing the need for an institutional level of care. A diagnosis of

Alzheimer's or other dementia related illness shall be prima facie evidence of a need for an institutional level of care; and

ii) shows the son or daughter resided with the person for two years immediately prior to the person's institutionalization. The evidence may consist of tax returns, driver's license, cancelled checks or other documentation demonstrating residence in the home for at least two years prior to the parent's institutionalization; and

iii) shows the son or daughter provided care to the person that prevented institutionalization. The evidence may consist of sworn affidavit or statement signed by the son or daughter.

2) the transfer:

A) by the institutionalized person was to:

i) the person's spouse or to another person for the sole benefit of the person's spouse;

ii) the person's child or to a trust (including a trust described in Section 120.347(d)) established solely for the benefit of the person's child or to another person for the sole benefit of the institutionalized person's child. To qualify under this subsection (m)(2)(A)(ii), the child must be determined blind (as described in Section 120.313) or determined disabled (as described in Section 120.314);

iii) a trust (including trusts described in Section 120.347(d)(1) and (2)) established solely for the benefit of a person who is determined disabled (as described in Section 120.314).

B) "sole benefit of" a person means:

i) the transfer is arranged in such a way that no person or entity except the specified beneficiary can benefit from the property transferred;

ii) the transfer instrument or document provides for the spending of the funds involved for the benefit of the person

on a basis that is actuarially sound, based on the life expectancy of the person involved (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration http://www.ssa.go/OACT/STAT/table4c6.html). Equal and periodic payments are not required. This subsection (m)(2)(B)(ii) does not apply to trusts described in Section 120.347(d) because those trusts provide for a "payback" to the State upon the death of the beneficiary;

iii) the transfer was accomplished via a written instrument of transfer (e.g., a trust document) that legally binds the parties to a specified course of action and clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document may not be said to have been made for the sole benefit of the person since there is no way to establish, without the document, that only the specified person will benefit from the transfer.

3) the person intended to transfer the property for fair market value (FMV). When a transfer is made for less than FMV, a person is presumed to have done so intentionally. This presumption may be rebutted by objective tangible evidence of the following (a subjective statement of intent or claim of ignorance of the asset transfer provision is not sufficient):

A) initial and continuing reasonable, good faith efforts to sell the property on the open market were made and that the compensation received was the best value offered;

B) a legally binding contract was executed that provided for adequate compensation in a specified form (e.g., goods, services, cash) in exchange for the transferred asset;

C) the person acted in good faith that he or she was receiving FMV or the best price for the item or property, and the item or property was transferred to a person other than a related party (e.g., a person related by blood, marriage or friendship);

D) the person had other adequate means or plans for support, including medical care, at the time of the transfer.

4) the transfer was made exclusively for a reason other than to qualify or remain eligible for medical assistance. A transfer for less than FMV is presumed to have been made to qualify for assistance. This presumption may be rebutted by credible tangible evidence that the person or spouse had no reason to believe that Medicaid payment of long term care services might be needed. The sudden loss of income or assets, the sudden onset of a disabling condition, such as a stroke or Alzheimer's disease, or a personal injury may provide convincing evidence that there was no reason to anticipate a need for long term care assistance. A subjective statement of intent or claim of ignorance of the asset transfer provision is not sufficient. Other examples of credible evidence showing a reason for transferring assets for reasons other than to qualify or remain eligible for medical assistance include, but are not limited to:

A) police reports, other related law or regulatory enforcement reports, documentation from the Department on Aging, or like credible evidence that assets were misappropriated as a result of elder or other abuse and cannot be recovered;

B) evidence that the transfer was made by a person lacking the mental capacity to make the transfer and who was not represented by a guardian, family member or other legal representative at the time of the transfer.

C) evidence that the transfers were for everyday living expenses, incidental gifts to family members, or contributions to charities or religious organizations made on a consistent basis over a period of time (not only in close proximity to applying for assistance). These expenses shall be reviewed taking into account the individual circumstances of a particular transfer and applying an objective standard based on whether a reasonable person would have made the transfer unmotivated by an intent to qualify for assistance; and

D) other evidence pertinent to the person's circumstances at the time of the transfer relating to:

i) the person's physical and mental condition;

ii) the person's financial situation;

iii) the need for medical assistance;

iv) any changes in living arrangements;

v) the length of time between the transfer and application for medical assistance; or

vi) whether unexpected events occurred between the transfer and application.

5) the person transfers property disregarded as a result of payments made by a qualified long term care insurance policy approved by the Director of the Illinois Department of Insurance under the Qualified Long Term Care Insurance Partnership (QLTCIP) program (50 Ill. Adm. Code 2012).

6) the assets transferred for less than FMV have been returned to the person.

A) For transfers occurring prior to January 1, 2012, if only parts of transferred assets are returned, a penalty period shall be reduced but not eliminated. For example, if only half the value of the asset is returned, the penalty period shall be reduced by one half.

B) For transfers occurring on or after January 1, 2012, all of the assets transferred for less than FMV must have been returned to the person. Full or partial returns occurring prior to imposition of a penalty reduce the uncompensated portion of the transfer by the amount returned. Once a penalty is imposed it may only be eliminated if all assets transferred for less than FMV are returned. When all transferred assets are returned, the assets are treated as returned on the date the penalty was imposed; the penalty is erased and the returned assets are treated as available as of the date the penalty was imposed. For the time period between imposition of the penalty and return of the assets, the Department will treat the assets as available to meet the spenddown obligation for that time period only (see Section 120.384). At the point in time that assets are in fact returned, they are treated as available assets that may be reduced by a spenddown obligation or otherwise. Returned assets that are transferred for less than FMV may be subject to penalty.

7) the Department determines that the denial of eligibility would cause an undue hardship as provided in subsection (r) of this Section.

n) The purchase of an annuity by or on behalf of an institutionalized person or the

spouse of that person shall be treated as a transfer of assets for less than FMV unless:

1) the annuity names the State of Illinois as the remainder beneficiary in the first position for up to the total amount of medical assistance paid on behalf of the institutionalized person; or

2) the annuity names the State of Illinois in the second position after the community spouse or minor child or child with a disability and is named in the first position if the spouse or a representative of the child disposes of any remainder for less than FMV.

o) The purchase of an annuity by or on behalf of an institutionalized person shall be treated as a transfer of assets for less than FMV unless:

1) the annuity is considered either:

A) an individual retirement annuity described in section 408(b) of the Internal Revenue Code (26 USC 408(b)); or

B) a deemed individual retirement account (IRA) under a qualified employer plan described in section 408(q) of the Internal Revenue Code (26 USC 408(q)); or

2) the annuity is directly purchased with proceeds from one of the following:

A) a traditional IRA described in section 408(a) of the Internal Revenue Code (26 USC 408(a));

B) certain accounts or trusts treated as traditional IRAs under section 408(p) of the Internal Revenue Code (26 USC 408(p));

C) a simplified employee pension described in section 408(k) of the Internal Revenue Code (26 USC 408(k)); or

D) a Roth IRA described in section 408A of the Internal Revenue Code (26 USC 408A); or

3) the annuity meets all the following requirements:

A) was purchased from a commercial financial institution or insurance company authorized under federal or State law to issue annuities;

B) is actuarially sound and based on the estimated life expectancy of the person (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration at http://www.ssa.gov/OACT/STATS/table4c6.html). Period certain annuities that pay out over a term less than the person's expected life shall be treated as actuarially sound;

C) is irrevocable and nonassignable; and

D) pays benefits in approximately equal periodic payments no less than quarterly, with no deferred or balloon payments.

p) Life Estates. The purchase of a life estate interest in another person's home shall be treated as a transfer for less than FMV unless the purchaser resided in the home for at least 12 consecutive months after the date of the transfer. If the purchaser resided in the home for less than 12 consecutive months, the entire purchase amount will be considered a transfer for less than FMV.

q) Promissory Notes, Loans and Mortgages. The purchase of a promissory note, loan or mortgage by a person shall be treated as a transfer of assets for less than FMV unless the following conditions are met (a promissory note, loan, or mortgage that does not satisfy these conditions shall be valued based on the outstanding balance due the person under the instrument as of the later of the date of application for medical assistance or the date of the transfer):

1) a written instrument recording the transaction is executed, signed and dated on the effective date of the transaction;

2) the instrument provides for a repayment term that is actuarially sound (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration at http://www.ssa.gov/OACT/STATS/table4c6.html). Instruments that provide for a repayment term that is less than the person's life expectancy shall be treated as actuarially sound;

3) the instrument provides for payments to be made in equal installments (no less than monthly) during the term of the loan with no deferral and no balloon payments;

4) the instrument prohibits the cancellation of the balance upon the death of a lender;

5) a tangible, verifiable record of consistent, timely payments in the amounts provided under subsection (q)(3) demonstrates a good faith attempt to repay the instrument. Unpaid installments delinquent three months or more will result in the Department treating the amount remaining unpaid on the instrument as a non-allowable transfer; and

6) the instrument provides for the assignment to the State of Illinois, as of the date of death, of up to the total amount of medical assistance paid on behalf of the institutionalized person; the State shall be placed in the first position of assignment or in the second position after the community spouse or minor child or child with a disability, and is named in the first position if the spouse or a representative of the child disposes of any remainder for less than FMV.

r) Hardship Waiver.

1) The Department shall waive a penalty period or a portion of a penalty period if it determines that application of a penalty creates an undue hardship. An undue hardship exists when application of a penalty would deprive an institutionalized person:

A) of medical care, endangering the person's health or life; or

B) of food, clothing, shelter, or other necessities of life.

2) The person requesting a hardship waiver shall have the burden of proof that actual, not just possible, hardship exists. The Department may require the person to provide written evidence to substantiate the circumstances of the transfer, attempts to recover the uncompensated value of the transfer, reasons for the transfer and the impact of a period of ineligibility for long term care services. The following criteria shall be considered in determining whether a hardship waiver may be granted:

A) whether credible evidence is presented that the person, in good faith and to the best of his or her ability, has taken all equitable and legal means available to recover an asset or assets that have been transferred for less than fair market value. In cases involving alleged theft, fraud, elder abuse or other misappropriation of assets, evidence of referrals to the police or other law or regulatory enforcement agencies is required;

B) the medical condition, mental capacity, financial ability and other

factors that may have affected the person at the time of the decision to transfer the assets for less than FMV;

C) the denial of assistance would force the person to move; and

D) subject to the availability of beds, the person would be prohibited from joining a spouse in a facility or from entering a facility that is in close proximity to his or her family.

3) Transfers Prior to November 1, 2011.
Notwithstanding the provisions of subsection (r)(2), and notwithstanding the January 1, 2012 implementation date of the look back period, for transfers occurring prior to November 1, 2011, a hardship waiver shall be granted if the applicant signs an attestation form stating that the penalized transfer was made in reliance on the administrative rules in effect at the time of the transfer and that, without a waiver, the person faces deprivation of the elements described in subsections (r)(1)(A) and (B).

4) A facility in which an institutionalized person is residing may request a hardship waiver on behalf of that person under this subsection (r) provided written consent has been obtained from the person if the person is legally competent to give that consent or from the person's personal representative, who may include the person who signed the application for medical assistance on behalf of the resident (see 89 Ill. Adm. Code 110.10(c)).

s) Records Production. The Department or its agent may request any and all records necessary to determine the existence and extent of any transfers of property under this Section. Persons are required to cooperate in providing requested information and verifications in accordance with Section 120.308. The Department will provide any needed assistance requested by a person and will use reasonable measures requesting records, taking into account the age, significance, relevancy and difficulty of obtaining the records, the medical condition and mental capacity of the person, and other factors that may affect the person's ability to retrieve records.

t) Notice.

1) The Department shall issue a notice to any person who is subject to a penalty period not less than 10 days prior to imposition of the penalty. The notice shall inform the person of the period of ineligibility for long term care services and include a statement that the person may appeal the

decision to impose a penalty period pursuant to 89 Ill. Adm. Code 102.80.

2) A notice of imposition of a penalty period shall inform the person that a hardship waiver under subsection (r) may be requested and that the person or facility in which the person resides may submit in writing (pursuant to subsection (r)(2)) evidence that a hardship exists. The evidence may be submitted to the Department, which shall review the information and, based on the criteria under subsection (r), determine whether a hardship waiver should be granted. Upon completion of its review, the Department shall issue a notice of decision on a request for a hardship waiver that shall include a statement that the person may appeal the decision pursuant to 89 Ill. Adm. Code 102.80.

(Source: Added at 35 Ill. Reg. 18645, effective January 1, 2012)

Section 120.390 Persons Who May Be Included In the Assistance Unit

a) MANG(C)

1) The assistance unit must include at least one eligible child or only an adult(s) caretaker relative whose eligibility is based on a child who is otherwise eligible except the child receives SSI. No more than two of the following individuals may be included as adults:

A) The caretaker relative;

B) The parent of an eligible child;

C) The needy relative other than the caretaker relative who provides at least one of the following services:

i) child care which enables the caretaker relative to work on a full-time (at least 100 hours per month) paid basis outside the home;

ii) care for an incapacitated family member in the home;

iii) child care that enables a caretaker relative to receive training full-time;

iv) child care that enables a caretaker relative to attend high school or General Educational Development (GED) classes full-time; or

v) child care for a period not to exceed two months that enables the caretaker relative to participate in a Project Chance (AFDC) work program such as Job Search.

2) The eligibility of a child in an Assistance unit depends on that child's lack of parental support or care. All eligible dependent children and stepchildren in a family unit shall be included in a single case, except in two-parent households where there are children of differing parentage, some of whom lack parental support or care because of the unemployment of a parent. In such a circumstance two separate assistance cases shall be established: one for both adults and children whose eligibility derives from their parent's unemployment and one for the remaining children. The provisions of this Section shall not affect the right of a child who is a parent to receive assistance in a separate case as a caretaker relative for

his/her dependent child.

b) MANG(AABD)
The eligible person only shall be included in the assistance unit.

c) MANG(P)
The assistance unit shall only include pregnant women and children born October 1, 1983, or later who meet the eligibility requirements of Section 120.11.

(Source: Amended at 16 Ill. Reg. 11582, effective July 15, 1992)

Section 120.391 Individuals Under Age 18 Who Do Not Qualify For AFDC/AFDC-MANG And Children Born October 1, 1983, or Later

a) Individuals Under Age 18

1) Medical assistance shall be provided to individuals under age eighteen (18) who do not qualify for AFDC under the definition of dependent child as defined in 89 Ill. Adm. Code 101.20 and 112.61 through 112.64. However, such individuals must meet the eligibility requirements and other provisions of 89 Ill. Adm. Code 112.10, 112.20, and 112.Subpart C.

2) If non-exempt countable income (see Sections 120.360 thru 120.375) is equal to or less than the appropriate MANG (AFDC) standard, (see Section 120.30) the individual is eligible for payment of his/her allowable medical care costs (see 89 Ill. Adm. Code 140.3).

3) Persons whose income exceeds the appropriate MANG (AFDC) standard are eligible for medical assistance each month incurred or paid medical care costs equal the amount of excess non-exempt income over the standard. When income exceeds the MANG (AFDC) standard, eligibility begins on the day in the month incurred or paid medical care costs equals excess monthly income. Eligibility ends on the last day of the same month.

b) Children Born October 1, 1983, or Later
Medical assistance shall be provided to children born October 1, 1983, or later who do not qualify as mandatory categorically needy (Social Security Act (42 U.S.C. 1902(a)(10)(A)(i) and 1905(n)) and meet the eligibility requirements of 89 Ill. Adm. Code 120.11, 120.31, 120.64.

(Source: Amended at 16 Ill. Reg. 11582, effective July 15, 1992)

Section 120.392 Pregnant Women Who Would Not Be Eligible For AFDC/AFDC-MANG If The Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy

a) Pregnant women who would not be eligible for AFDC/AFDC-MANG if the child were already born

1) Medical assistance shall be provided to women of any age who are pregnant and meet the asset standards (see Sections 120.380 thru 120.382) of the AFDC medical assistance program and who would not be eligible for AFDC if the child were already born because:

A) the father is not absent, and

B) neither parent is incapacitated (see 89 Ill. Adm. Code 112.62) and the principal wage earner does not meet the Department's definition of unemployment (see 89 Ill. Adm. Code 112.64).

2) Medical assistance for up to sixty (60) days following the last day of pregnancy.

A) Medical assistance shall be provided for the woman and newborn child for up to sixty (60) days following the last day of the pregnancy. The sixty (60) day medical coverage continues through the last day of the calendar month in which the sixty (60) day period ends.

B) In order for a pregnant woman to qualify for the extended sixty (60) day medical coverage, an AFDC MANG application must have been filed prior to the date the pregnancy ended.

b) Pregnant women who do not qualify as mandatory categorically needy

1) Medical assistance shall be provided to women of any age who do not qualify as mandatory categorically needy (Sections 1902(e)(10)(A)(i) and 1905(n) of the Social Security Act) and meet the eligibility requirements of Sections 120.11, 120.31 and 120.64).

2) Medical assistance shall be provided for the woman and newborn child(ren) for up to sixty (60) days following the last day of the pregnancy. The sixty (60) day medical coverage continues through the last day of the calendar month in which the sixty (60) day period ends.

(Source: Amended at 12 Ill. Reg. 19704, effective November 15, 1988)

Section 120.393 Pregnant Women And Children Under Age Eight Years Who Do Not Qualify As Mandatory Categorically Needy Demonstration Project

The Department shall conduct a six-month demonstration project in Macon County and the Garfield and Western local offices of Cook County to test the impact of providing Medicaid to pregnant women and children under age eight years who do not qualify as mandatory categorically needy and whose incomes are no more than 185 percent of the Federal Poverty Income Guidelines.

(Source: Added at 13 Ill. Reg. 15404, effective October 6, 1989)

Section 120.395 Payment Levels for MANG (Repealed)

(Source: Repealed at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.399 Redetermination of Eligibility

It is the Department's responsibility to determine the continued eligibility of all recipients of medical assistance and it is the recipient's responsibility to cooperate in the redetermination of eligibility. A redetermination of eligibility shall be conducted at least every twelve months and at any time it becomes known to the Department that a recipient's circumstances affecting eligibility may have changed.

(Source: Amended at 25 Ill. Reg. 16098, effective December 1, 2001)

Section 120.400 Twelve Month Eligibility for Persons under Age 19

a) Coverage under the Department's Medical Assistance Program shall be provided for all eligible persons under 19 years of age for a 12 month period, regardless of any changes in income that may occur during that period, except as provided in subsections (c) and (d) of this Section. Provisions under this Section are not applicable to persons under age 19 who do not experience any changes in circumstances and continue to meet all medical assistance eligibility requirements.

b) The 12 month period shall begin the later of:

1) the month in which initial eligibility is determined; or

2) the month in which eligibility has most recently been determined.

c) Eligibility shall end when the earliest of the following occurs:

1) the 12 month period ends; or

2) the person attains age 19; or

3) the person is no longer a resident of Illinois; or

4) the person is incarcerated; this provision shall not apply effective January 1, 2012; or

5) the person dies; or

6) the Department determines that, at the time of application, incorrect or inaccurate information was provided that affected the eligibility determination; or

7) the caretaker relative requests termination; or

8) the child is also the caretaker relative of a child receiving benefits under the Public Aid Code and fails to cooperate with the support enforcement for that child as required by 89 Ill. Adm. Code 160.30; or

9) the Department determines that the child was incorrectly determined to be eligible.

d) Twelve month eligibility under this Section shall not apply to any person who:

1) has only been determined to be presumptively eligible; or

2) has a spenddown; or

3) has only been determined eligible for emergency medical assistance under Section 120.310(b)(3).

(Source: Amended at 35 Ill. Reg. 379, effective December 27, 2010)

SUBPART I: SPECIAL PROGRAMS

Section 120.500 Health Benefits for Persons with Breast or Cervical Cancer

a) A person shall be eligible for medical assistance if the person meets the following eligibility requirements under Health Benefits for Persons with Breast or Cervical Cancer (BCC):

1) Cooperates in establishing eligibility as described in Section 120.308.

2) Meets citizenship/immigration status as described in Section 120.310.

3) Meets residency requirements as described in Section 120.311.

4) Assigns rights to medical support and collection of payment as described in Section 120.319.

5) Furnishes a Social Security number as described in Section 120.327.

6) Is under the age of 65 years.

7) Has been screened for breast or cervical cancer under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) administered by the Illinois Department of Public Health (IDPH) as described in subsection (c) of this Section, and has been found to need treatment, as defined in subsection (d) of this Section, for breast or cervical cancer or a precancerous condition as defined in subsection (e) of this Section.

8) Continues to need treatment as defined in subsection (d) of this Section.

9) Is uninsured, that is, must not have creditable coverage, as defined under the Health Insurance Portability and Accountability Act, for breast or cervical cancer treatment.

b) A person shall not be determined eligible for Health Benefits for Persons with Breast or Cervical Cancer:

1) if, upon screening by the Department, the person is found to be otherwise eligible for medical assistance under Section 120.11, 120.20 or 120.30 without a spenddown; or

2) if the person is in a correctional facility pursuant to 42 CFR 435.1008.

c) A person shall meet the screening requirement if:

1) the person's breast or cervical cancer screening was conducted within the scope of a grant, sub-grant or contract under the NBCCEDP administered by IDPH; or

2) beginning September 1, 2006, the person's diagnosis of breast or cervical cancer or precancerous cervical condition was confirmed by an entity receiving a grant, sub-grant or contract under the NBCCEDP administered by IDPH.

d) A person shall be considered to need treatment if, in the opinion of the person's treating physician, the person requires therapy directed toward cure or palliation of breast or cervical cancer, including recurrent metastatic cancer that is a known or presumed complication of breast or cervical cancer and complications resulting from the treatment modalities themselves. Treatment includes diagnostic services that may be necessary to determine the extent and proper course of treatment. Persons who require only routine monitoring services (for example, pap smears or mammograms) are not considered to need treatment.

e) For the purposes of this Section, a precancerous condition means:

1) Cervical intraepithelial neoplasia, grade III (CIN III);

2) Severe dysplasia of the cervix;

3) High-grade squamous intraepithelial lesion (HGSIL); or

4) Atypical glandular cells of undetermined significance (AGUS) with a suspicion of adenocarcinoma in situ.

f) All assets shall be exempt from consideration in determining eligibility under this Section.

g) A person's eligibility for medical assistance under this Section shall be terminated when the person no longer meets the requirements of this Section.

h) Application Process

1) The process of applying for medical assistance shall be initiated by the submission to the Department, by an entity designated by IDPH, of a statement certifying that a person meets the condition of eligibility described in subsection (a)(7) of this Section.

2) The Department shall contact the person by telephone, mail or other appropriate means to complete an application.

3) The application date shall be the date a signed application is received in the Department's central breast and cervical cancer eligibility unit.

4) Application may be made by additional methods that the Department establishes.

5) Applications shall meet all requirements found at 89 Ill. Adm. Code 110.10(a), (c), (e) and (i).

6) A BCC application is only an application for Health Benefits for Persons with Breast or Cervical Cancer.

i) Authorization of Medical Assistance Eligibility

1) Eligibility will be effective no earlier than the third month before the month of application if the applicant would have been eligible if he or she had applied. In no case shall eligibility be effective prior to July 1, 2001, for persons meeting the screening requirement described in subsection (c)(1) of this Section, or prior to September 1, 2006, for persons meeting the screening requirement described in subsection (c)(2) of this Section.

2) Eligibility can begin no earlier than the following:

A) for persons meeting the screening requirement described in subsection (c)(1) of this Section, the month in which the applicant was screened as described in subsection (a)(7) of this Section; or

B) for persons meeting the screening requirement described in subsection (c)(2) of this Section, the month in which the applicant received the test or procedure that resulted in a diagnosis of breast or cervical cancer or one of the precancerous cervical conditions described in subsection (e) of this Section.

j) Persons enrolled in Health Benefits for Persons with Breast or Cervical Cancer shall be exempt from Sections 102.210 and 102.230.

k) Persons enrolled in Health Benefits for Persons with Breast or Cervical Cancer who enter a nursing facility must provide income information sufficient for the Department to calculate a group care credit, as established in Sections 120.40 and

120.60, except that assets shall not be counted. The Department will not pay for nursing facility services for any person who refuses to provide the required information.

l) Persons applying for or enrolled in Health Benefits for Persons with Breast or Cervical Cancer shall be entitled to appeal rights as described at 89 Ill. Adm. Code 102.80-83.

(Source: Amended at 31 Ill. Reg. 2629, effective January 28, 2007)

Section 120.510 Health Benefits for Workers with Disabilities

a) To be eligible for medical assistance under Health Benefits for Workers with Disabilities, an individual must meet all of the following eligibility requirements:

1) Cooperate in establishing eligibility as described in Section 120.308.

2) Meet citizenship/immigration status as described in Section 120.310.

3) Meet residency requirements as described in Section 120.311.

4) Be disabled as described in Section 120.314.

5) Assign rights to medical support and collection of payment as described in Section 120.319.

6) Furnish a Social Security number(s) as described in Section 120.327.

7) Be 16 through 64 years of age.

8) Have countable monthly income at or below 350 percent of the Federal Poverty Level.

9) Have non-exempt assets at or below $25,000.

10) Be employed pursuant to subsection (l)(1) of this Section or qualify for an exception as described in subsection (l)(2) of this Section.

11) Pay a premium pursuant to subsections (m) and (n) of this Section.

b) An individual shall not be determined eligible if the individual is otherwise eligible for medical assistance without a spenddown.

c) An individual who is otherwise eligible for medical assistance with a spenddown and who meets the requirements of this Section shall have the option of enrolling in medical assistance with a spenddown or Health Benefits for Workers with Disabilities.

d) An individual's eligibility shall be terminated if the individual no longer meets the requirements of this Section.

e) Certain assets shall be exempt from consideration in determining eligibility in accordance with Section 120.381. In addition, retirement accounts that the

individual cannot access without penalty before the age of 59½ and medical savings accounts established pursuant to 26 USC 220 shall be exempt.

f) The earned and unearned income of the following persons shall be counted when determining eligibility, except as specified in subsections (g), (h) and (i) of this Section.

1) Income of the individual.

2) Income of the spouse.

3) Unearned income of a dependent child under the age of 18 years who is included in the income standard (see Section 120.20) because it is to the advantage of the individual.

g) Monthly unearned income shall be counted as described in Sections 120.330 through 120.345 and Sections 120.350, 120.355, 120.371 and 120.376.

h) Monthly earned income shall be considered as described in Sections 120.360, 120.361, 120.371, 120.372, 120.373 and 120.375.

i) The Department shall exempt earned income as provided in Section 120.362(a) and (b)(1). In addition, work related expenses that are allowed as deductions for AABD MANG as described in Section 120.370 shall be deducted.

j) Application Process

1) Individuals can apply by completing an application provided by the Department and submitting it to an address specified by the Department.

2) The application must meet all requirements found at 89 Ill. Adm. Code 110.10(a), (c), (e) and (i).

k) Authorization of Medical Assistance Eligibility

1) Medical assistance coverage will not be provided for any month for which eligibility is established unless a premium is paid in accordance with subsections (m) and (n) of this Section.

2) Subject to subsections (k)(2)(A), (B) and (C) of this Section, the applicant may choose to receive medical assistance for months prior to the initial month of prospective eligibility as determined in accordance with subsections (m) and (n) of this Section.

A) Eligibility will be effective no earlier than the third month before the month of application if the applicant received covered medical services during that period and would have been eligible if he or she had applied for Health Benefits for Workers with Disabilities.

B) Months of backdated coverage selected must be consecutive and must be continuous with the initial month of prospective eligibility.

C) Monthly premiums must be paid for all the months of coverage.

l) Individuals Considered Employed

1) For purposes of this program, an individual shall be considered employed if the individual provides verification that current payment under the Federal Insurance Contributions Act (FICA) or Illinois Municipal Retirement Fund (IMRF) has been made on behalf of the individual.

2) Under the following circumstances, an individual may be enrolled in this program without providing evidence of employment as described in subsection (l)(1) of this Section:

A) Individuals who are not employed at the time of application, but who can verify that they will be employed within 60 days, may be enrolled but will not be considered eligible until they begin employment and pay the appropriate premium in accordance with subsections (m) and (n) of this Section.

B) Individuals who become unable to work for medical reasons after enrollment in this program who wish to remain in the program. Such individuals:

i) Must report to the Department within 30 days after the first day that they were unable to work.

ii) Must provide a physician's written statement that they are unable to work, but that the anticipated date for the return to work is within 90 days after the first day they were unable to work.

iii) Must pay premiums in accordance with subsections (m) and (n) of this Section for the months during which they do not work.

C) Individuals who cease employment for any other reason may continue to be enrolled for 30 days after the employment ends provided they pay premiums in accordance with subsections (m) and (n) of this Section for the period during which they do not work.

3) Eligibility shall be terminated:

A) If an individual determined to be employed according to subsection (l)(2)(A) of this Section does not provide evidence of employment pursuant to subsection (l)(1) of this Section within 30 days after enrollment.

B) If an individual is unable to work for medical reasons, as described in subsection (l)(2)(B) of this Section, for 90 days or more.

C) If an individual ceases employment for any other reason (subsection (l)(2)(C) of this Section) and does not obtain new employment within 30 days after cessation of employment.

m) Premiums

1) The Department must receive payment of the monthly premium for an applicant's initial prospective month of eligibility before the applicant can be enrolled in this program. If payment of the premium is received by the 20th day of the month, the initial month of prospective eligibility shall begin the first day of the following month. (For example, if the premium payment is received on February 20, coverage shall begin on March 1. If the premium payment is received after February 20 but before March 21, coverage shall begin on April 1.)

2) Premiums for months of backdated coverage must be paid within 90 days after the date of the notice of eligibility approval.

3) Subsequent premiums are due on the last day of the month prior to the month of coverage.

4) If payment of the premium is not received in full by the end of the month following the due date of the premium, coverage will terminate effective the end of the second month following the due date and collection action may be initiated by the Department for the unpaid premiums for months of coverage.

n) Determination of Premium Amount

1) Premiums shall be based upon an individual's combined gross unearned and countable earned income as determined at the point of application or review or redetermination of eligibility.

2) The Department shall reset a premium prospectively based on verified income.

3) Premium amounts shall be established as set forth in the following monthly premium tables.

$s Per Month

Countable Earned Income	Gross Unearned Income											
	0-250	251-500	501-750	751-1000	1001-1250	1251-1500	1501-1750	1751-2000	2001-2250	2251-2500	2501-2750	2751-3000
0-250	--	19	38	56	75	94	113	131	150	169	188	206
251-500	6	25	44	63	81	100	119	137	156	175	194	212
501-750	13	31	50	69	88	107	126	144	163	182	201	219
751-1000	19	38	56	75	94	113	132	150	169	188	207	225
1001-1250	25	44	63	81	100	119	137	156	175	194	213	231
1251-1500	31	50	79	87	106	125	144	162	181	200	219	237
1501-1750	38	57	76	94	113	132	151	169	188	206	226	244
1751-2000	44	63	82	100	119	138	157	175	194	213	232	250
2001-2250	50	69	88	106	125	144	163	181	200	219	238	256
2251-2500	56	75	94	112	131	150	169	187	206	225	244	262
2501-2750	63	82	101	119	138	157	176	194	213	232	251	269
2751-3000	69	88	107	125	144	163	182	200	219	238	257	275
3001-3250	75	94	113	131	150	169	188	206	225	244	263	281

3251-3500	81	100	119	137	156	175	194	212	231	250	269	287
3501-3750	88	107	126	144	163	182	201	219	238	257	276	294
3751-4000	94	113	132	150	169	188	207	225	244	263	282	300
4001-4250	100	119	138	156	175	194	213	231	250	269	288	306
4251-4500	106	125	144	162	181	200	219	237	256	275	294	312
4501-4750	113	132	151	169	188	207	226	244	263	282	301	319
4751-5000	119	138	157	175	194	213	232	250	269	288	307	325
5000 +	125	144	163	181	200	219	238	256	275	294	313	331

$s Per Month

Countable Earned Income	Gross Unearned Income								
	3001-3250	3251-3500	3501-3750	3751-4000	4001-4250	4251-4500	4501-4750	4751-5000	5000+
0-250	225	244	263	281	300	319	338	356	375
251-500	231	250	269	287	306	325	344	362	381
501-750	238	257	276	294	313	332	351	369	388
751-1000	244	263	282	300	319	338	357	375	394
1001-1250	250	269	288	306	325	344	363	381	400
1251-1500	256	275	294	312	331	350	369	387	406
1501-1750	263	282	301	319	338	357	376	394	413
1751-2000	269	288	307	325	344	363	382	400	419
2001-2250	275	294	313	331	350	369	388	406	425
2251-2500	281	300	319	337	356	375	394	412	431
2501-2750	288	307	326	344	363	382	401	419	438
2751-3000	294	313	332	350	369	388	407	425	444
3001-3250	300	319	338	356	375	394	413	431	450
3251-3500	306	325	344	362	381	400	419	437	456
3501-3750	313	332	351	369	388	407	426	444	463
3751-4000	319	338	357	375	394	413	432	450	469

4001-4250	325	344	363	381	400	419	438	456	475
4251-4500	331	350	369	387	406	425	444	462	481
4501-4750	338	357	376	394	413	432	451	469	488
4751-5000	344	363	382	400	419	438	457	475	494
5000+	350	369	388	406	425	444	463	481	500

o) Medicaid Buy-In Program Revolving Fund (see 305 ILCS 5/12-10.6)

1) The Medicaid Buy-In Revolving Fund consists of premiums paid by eligible individuals under this Section.

2) Monies in the Fund may be used to pay costs incurred by the Department for:

A) Administering the Health Benefits for Workers with Disabilities (HBWD) program, including, but not limited to, staff, equipment, travel, outreach activities and other operating costs.

B) Personal assistance services (PAS) provided at an individual's work site. PAS under the HBWD program is limited to individuals who do not already receive PAS, have a need for such services on the basis of a disability as described in Section 120.314, and, except for their income and non-exempt assets, would be eligible for the Community Care Program as described at 89 Ill. Adm. Code 240. The need, amount and duration of PAS will be assessed through a determination of need process.

(Source: Amended at 33 Ill. Reg. 1681, effective February 1, 2009)

SUBPART I: SPECIAL PROGRAMS

Section 120.520 SeniorCare (Repealed)

(Source: Repealed at 30 Ill. Reg. 10314, effective May 26, 2006)

Section 120.530 Home and Community Based Services Waivers for Medically Fragile, Technology Dependent, Disabled Persons Under Age 21

a) The Department shall administer a home and community-based service (HCBS) waiver program as set forth in 305 ILCS 5/5-2(7) and 305 ILCS 5/5-2.05(a) and pursuant to Section 1915(c) of the Social Security Act (42 USC 1396n(c)) for disabled persons under the age of 21 years who are medically fragile and technology dependent.

b) A determination must be made that, except for the provision of in-home care, these individuals would require the level of care provided in a hospital or a skilled nursing facility.

c) The Division of Specialized Care for Children (DSCC) shall perform operational functions under the HCBS waiver program pursuant to an interagency agreement with the Department.

d) In addition to being eligible for all of the services set forth in 89 Ill. Adm. Code 140.3, individuals covered under the HCBS waiver are eligible for the following waiver services:

1) Respite care;

2) Environmental modifications;

3) Special medical supplies and equipment;

4) Medically supervised day care;

5) Family and nurse training; and

6) Maintenance counseling.

e) The Department shall determine eligibility. An individual meeting the following criteria shall qualify:

l) The individual is younger than 21 years of age;

2) The individual is disabled as defined in Section 120.314;

3) The individual scores a minimum of 50 points on the level of care screening described in subsection (h) of this Section;

4) The estimated cost of the individual's in-home care to be paid by the State shall not be greater than the institutional level of care appropriate to the individual's medical needs (hospital or skilled nursing facility), as determined by the Department:

A) if the appropriate comparable institutional level of care for a ventilator dependent individual is a hospital, the greater of:

i) 125 percent of the Statewide average per diem expenditure for hospital care for the previous fiscal year; or

ii) 100 percent of the average per diem expenditure provided in the hospital from which the individual was placed; or

B) if the appropriate comparable institutional level of care for a non-ventilator dependent individual is a hospital, 125 percent of the Statewide average per diem expenditure for hospital care in the previous fiscal year; or

C) if the appropriate comparable institutional level of care for the individual is a skilled nursing facility:

i) the per diem rate of the geographically closest skilled nursing facility meeting the individual's medical needs; or

ii) if the individual requires exceptional care services the per diem rate will be a blended rate based on the private pay rate for the geographically closest skilled nursing facility meeting the individual's medical needs and the Statewide average rate for medical assistance clients requiring a similar level of care;

5) The individual would be eligible for Medicaid if his or her responsible relative's income and resources were excluded from consideration; and

6) A written plan of care has been developed and approved pursuant to subsection (f) of this Section.

f) Plan of Care

1) The Department shall determine the home and community-based services based on a written plan of care developed in consultation with the individual's family or guardian, attending physician and DSCC care

coordinator.

2) At a minimum, the plan of care shall identify an appropriate primary residence, describe the medical and other services to be furnished, the frequency of the services, the type of provider required to render the service and a description of the family's or guardian's active participation, to the fullest extent possible, as caregivers in meeting the individual's medical needs.

3) The Department may, in its discretion, approve a cost-effective alternative to services in the plan of care, as long as the alternative services meet the medical needs of the individual.

4) When determining the hours of care necessary to maintain the individual at home, consideration shall be given to the availability of other services, including direct care provided by non-paid caregivers, such as, but not limited to, the individual's family or guardian, that can reasonably be expected to meet the medical needs of the individual.

5) The Department will review the individual's plan of care to determine continued eligibility for participation in the waiver on the following schedule:

A) During the first 18 months of participation in the waiver, a review will be performed every six months.

B) After the first 18 months, a review will be performed every six months and, depending upon the individual's medical condition, the plan of care may be approved for a period not to exceed 12 months.

C) Based on the results of the Department's review, a new plan of care may be developed if warranted by a change in the individual's need for medical services or a change in the individual's home environment.

g) Eligibility Denials or Terminations

1) An individual shall not be determined eligible for coverage under the waiver if:

A) The individual requires institutionalization solely because of a severe mental or developmental impairment.

B) The individual does not meet the minimum score required under subsection (e)(3) of this Section.

2) Termination of coverage under the waiver shall be initiated upon the occurrence of any of the following events:

A) Failure of a family or guardian to cooperate with the Department, DSCC, or service providers in implementing a plan of care, if the Department determines that, as a result of that non-cooperation, a plan of care cannot be implemented or the health and well being of the individual could be jeopardized.

B) Upon renewal for continued participation in the waiver, the individual does not meet the minimum score required under subsection (e)(3) of this Section.

C) The individual does not require at least one of the services described under subsection (d).

D) The individual attains the age of 21 years of age.

3) A transition period of no more than 60 days, during which the individual will continue to receive services through the waiver, will be provided on terminations resulting from subsections (g)(2)(B) and (C) of this Section.

h) DSCC shall perform a level of care screening for the waiver as follows:

1) The level of care screening will be performed using a Department approved screening tool.

2) The level of care screening will be performed as follows:

A) On all new requests for admission to the waiver;

B) On all renewals for continued participation in the waiver; and

C) Whenever there is a significant change in the participant's status or care needs.

3) The level of care screening will consist of the following elements:

A) Technology needs will be screened to determine the risk of

disability or death if the technology is lost, as well as the degree of skill for assessment and judgment needed to operate the technology; and

B) Medical fragility will be screened to determine the frequency and need for skilled care.

(Source: Amended at 33 Ill. Reg. 2289, effective March 1, 2009)

Section 120.540 Illinois Healthy Women Program

a) A woman shall be eligible for medical services under this program if the woman:

1) Meets required citizenship/immigration status as described in Section 120.310;

2) Meets residency requirements as described in Section 120.311;

3) Does not reside in a public institution as described in Section 120.318;

4) Furnishes a Social Security Number as described in Section 120.327;

5) Is 19 through 44 years of age;

6) Has monthly countable income equal to or less than 200 percent of the federal poverty level guideline.

A) Monthly countable income is determined by taking the total gross monthly income of the woman, and her spouse if she is married and living with her spouse, and subtracting allowable deductions and exemptions according to the provisions of Subpart H, except that sections 120.335(a), 120.345(b), 120.355(a), 120.360(d), 120.362(a) and (b), 120.364, 120.366, 120.370(a), 120.371(c), 120.373(a) and 120.379 shall not apply.

B) The number of individuals in the family determines the applicable income standard.

b) A woman meeting the criteria described under subsection (a) of this Section will be automatically enrolled in the program if she lost eligibility for medical assistance under this Part or health benefits under 89 Ill. Adm. Code 125 for a reason other than failing to meet one of the criteria listed in subsection (a) of this Section.

c) Women who are not enrolled automatically under subsection (b) of this Section may apply for the program by submitting an Illinois Healthy Women application to an address specified by the Department or alternative methods that the Department establishes.

1) The application must meet all requirements found at 89 Ill. Adm. Code 110.10, including provisions regarding who may apply on behalf of the woman.

2) Applicants are obligated to provide truthful and accurate information for determining eligibility and to report promptly to the Department any change in non-financial information provided on the application.

3) Applicants will be notified, in writing, regarding the outcome of the determination of their eligibility.

d) Initial coverage will begin as follows:

1) For women enrolled under subsection (b) of this Section, initial coverage will automatically commence beginning on the first day of the month following the last month of medical assistance or health benefits coverage and will continue for three months. If, in the prescribed timeframe of three months for initial coverage, the woman signs and returns the enrollment form that is mailed to her by the Department, eligibility will continue for an additional nine months beginning on the first day of the month that follows the third month of initial coverage.

2) For women enrolled under subsection (c) of this Section, upon determination of eligibility, initial coverage will commence on the first day of the month in which the application was received by the Department and will continue for 12 months.

e) Eligibility must be redetermined once every 12 months.

1) If the woman continues to meet the requirements set forth in subsection (a), the woman will remain eligible for an additional 12 months if, within the prescribed timeframe, she signs and returns the re-enrollment form that is mailed to her.

2) If the woman does not continue to meet the requirements set forth in subsection (a) or if she does not sign and return the re-enrollment form, her eligibility for the program will be terminated.

3) Each woman will be notified, in writing, regarding the outcome of her re-determination of eligibility.

f) A re-enrollment form will not be mailed to the woman if, after coverage under this program began:

1) She reached the age of 45 years;

2) She moved out of Illinois;

3) She became eligible for another medical program under this Part or 89 Ill. Adm. Code 125;

4) She became an inmate of a correctional facility or a resident of a public institution;

5) She requested that benefits be terminated; or

6) The Department paid for a sterilization procedure for her.

g) Coverage for all participants shall end upon termination of the federal waiver under which this coverage is provided.

h) Benefits available under this program are those set forth in 89 Ill. Adm. Code 140.486.

(Source: Amended at 31 Ill. Reg. 12756, effective August 27, 2007)

Section 120.550 Asylum Applicants and Torture Victims

a) To be eligible for medical assistance as an applicant for asylum or a torture victim, an individual must:

1) Have an application for asylum pending before the federal Department of Homeland Security, or an appeal pending regarding a decision of asylum status before a court of competent jurisdiction, and is represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or

2) Be receiving treatment services for torture from a federally funded torture treatment center that has been recognized by the Department.

b) Additionally, an individual must meet all of the following eligibility requirements:

1) Cooperate in establishing eligibility as described in Section 120.308.

2) Be a resident of Illinois.

3) Assign rights to medical support and collection of payment as described in Section 120.319.

4) Be 19 years of age or older.

5) Have countable monthly income at or below 100 percent of the Federal Poverty Level as described in Section 120.20(a).

6) Have non-exempt assets at or below the AABD MANG asset disregard level as described in Section 120.382, and certain assets shall be exempt from consideration in determining eligibility in accordance with Section 120.381.

c) An individual shall not be determined eligible if the individual is otherwise eligible for medical assistance under the Public Aid Code [305 ILCS 5], or otherwise eligible for benefits including rebates under the Children's Health Insurance Program Act [215 ILCS 106] or the Covering ALL KIDS Health Insurance Act [215 ILCS 170].

d) Individuals eligible under this Section are exempt from the requirements as described in Section 120.310 pertaining to citizenship and eligible non-citizens.

e) Individuals shall not be denied eligibility under this Section for failure to provide a Social Security Number or proof of having applied for a Social Security Number as otherwise required in Section 120.327.

f) The earned and unearned income of the following persons shall be counted when determining eligibility, except as specified in subsections (g) and (h) of this Section.

1) Income of the individual.

2) Income of the spouse.

3) Unearned income of a dependent child under the age of 18 years who is included in the income standard (see Section 120.20) because it is to the advantage of the individual.

g) Monthly earned and unearned income shall be considered as described in Sections 120.330 through 120.345, Sections 120.350 through 120.361 and Sections 120.371 through 120.376 as specified for AABD MANG.

h) The Department shall exempt earned income as provided in Section 120.362(a). In addition, work related expenses that are allowed, as deductions for AABD MANG, as described in Section 120.370, shall be deducted.

i) Application Process

1) Individuals can apply by completing an application provided by the Department and submitting it to an address specified by the Department.

2) The application must meet all requirements found at 89 Ill. Adm. Code 110.10(a), (c) and (e).

3) The application date shall be the date a signed application is received at the address specified by the Department and can be no sooner than July 1, 2007.

j) Eligibility will be effective no earlier than the third month before the month of application if the applicant would have met the criteria of this Section had he or she applied. In no case shall eligibility be effective prior to April 1, 2007.

k) Eligibility under this Section will be redetermined every 12 months, or when a change is reported.

l) Eligibility under this Section shall be limited to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this Section and subject to the following:

1) An individual who has a break in coverage during the 24 months commencing with the initial eligibility date may reenroll if all eligibility criteria are met but such break in coverage shall not extend his or her period of eligibility; and

2) Eligibility under this Section shall be extended an additional 12 months or until a final decision is rendered on the appeal, whichever occurs sooner, for an individual who has an appeal pending regarding an application for asylum before the Department of Homeland Security.

m) An individual's eligibility shall be terminated if the individual no longer meets the requirements of this Section.

n) Persons applying or enrolled under this Section shall be entitled to appeal rights as described in 89 Ill. Adm. Code 102.80 through 102.83.

o) Eligibility under this Section is not an entitlement and is subject to available funding. The Department may take appropriate action to limit enrollment under this Section including, but not limited to, ceasing to accept or process applications or reviewing eligibility more frequently than annually.

(Source: Added at 31 Ill. Reg. 11667, effective August 1, 2007)

Section 120.TABLE A Value of a Life Estate and Remainder Interest

Age	Life Estate	Remainder
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540

37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258

78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

(Source: Added at 19 Ill. Reg. 2905, effective February 27, 1995)

Section 120.TABLE B Life Expectancy (Repealed)

(Source: Repealed at 35 Ill. Reg. 18645, effective January 1, 2012)